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**Personal Autonomy and Health Policy:
Some Considerations in
Political Theory**

by

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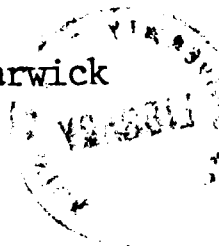
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Abstract of Thesis

This thesis examines some of the implications for social policy of an account of human nature frequently associated with liberal political theory. Taking as its starting point the claim that the objectives of social policy are contested, it seeks to develop an account of autonomy that will serve as a neutral 'organizational principle' around which to construct social policy. A particular version of personal autonomy is developed and defended against both abstract Kantian moral autonomy, and the individualism often associated with liberal theories. This project is pursued first through a discussion of the relationship of autonomous persons to 'social forms', and then through a critique of libertarian and 'intellectualist' accounts of autonomy. It is argued that, since autonomy is not only employed in the making of choices, but also in the implementing of those choices, it follows that the autonomous person must, of necessity, be viewed 'holistically' for the body is the primary means of implementing the choices autonomous persons make. The health of the body, as well as that of the mind, therefore assumes importance for any social policy that takes autonomy to be a fundamental objective. The implications for such an account of social policy are then explored in two ways. First, through a discussion of the phenomenon of 'medicalization'. Second, through a discussion of the **Prevention and Health** campaign. In the first instance, it is argued that the assumption that medicalization systematically undermines autonomy is ill-founded because theories of medicalization misunderstand what it is to be autonomous. In the second instance, the discussion of preventive health-care policy serves to illustrate the fundamentally erroneous assumptions of individually-focussed health-care programmes. In conclusion, it is argued that a unified account of autonomous persons must inevitably lead to a more integrated social policy.

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Alan Apperley, September 1991

Our central concern in the work that follows can be simply stated: it is to examine a particular account of what it is to be a human being, and to draw out some of the implications for social policy of that account. In other words, we shall be examining the practical implications of a theoretical construct. But although simply stated, such a task is fraught with difficulties. In **section i** of this introduction we shall concern ourselves with setting out some of these difficulties in order to make explicit at least some of the limitations of the task we shall be undertaking. We begin with some brief comments on what we take, at least within the terms of this thesis, to be the purposes that theories in general may be said to serve, and how they relate us to the world in which we live. We shall then comment briefly on our interest in the concept of autonomy, locating it in relation to an important dichotomy within political theory. We next turn to a brief discussion concerning the reflexive mode of argument employed by a number of political and social theorists to defend autonomy-based accounts of social policy. Having established (in **section i**) the parameters of the thesis, we turn, in **section ii**, to the thesis itself, giving a brief chapter-by-chapter outline of the overall argument.

* * * * *

i: The Importance of Theory

Broadly speaking, theories are said to serve two main purposes. They either serve to explain reality - explain, that is, why things are as they are and not otherwise - or they serve to guide action. The usual way to state this dichotomy is to say that theories may be either explanatory, or they may be normative; they may be descriptive, or they

may be prescriptive. It is often thought good practice to keep these dichotomous functions apart; to conflate the two is to commit what G.E. Moore called (in his Principia Ethica) the 'naturalistic fallacy'. The error is said to consist in deriving ethical conclusions (statements about what one ought to do) from factual premises (statements about what is the case)¹. A crude example will illustrate the point. Jeremy Bentham's 'principle of utility' (that all human beings are placed under the governance of two sovereign masters, pain and pleasure) purports to be a descriptive account of human psychology. But it does not obviously entail the prescriptive greatest happiness principle (act so as to maximise the greatest happiness of the greatest number) since it is possible that, in maximising the greatest happiness of the greatest number, one's own happiness may have to be sacrificed. It becomes clear then that individuals are being exhorted to act, at least on occasion, against their own interests, and this they are held to be psychologically incapable of doing². In other words, the prescriptive part of Bentham's theory (the greatest happiness principle) does not seem to follow from the descriptive part (the principle of utility) and might in fact be in conflict with it.

But it is not always easy to keep the two kinds of statement distinct, because the way one understands or describes the world may itself entail certain courses of action (where 'entail' is used in a weak sense to avoid the implication that one is compelled so to act), or it may at

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1. G.E. Moore, Principia Ethica, (Cambridge: Cambridge University Press, 1903), pp.10-21. An earlier version can be found in David Hume's A Treatise of Human Nature, Edited by A. Selby-Bigge, second edition revised by P.H. Nidditch, (Oxford: Oxford University Press, 1978), p.469
 2. This point is made by Jack Lively and John Rees (Eds.), Utilitarian Logic and Politics, (Oxford: Clarendon Press, 1978), pp.40-42

least render certain courses of action inadmissible. This realisation can be said to have informed the writings of both Kant and Hegel, and possibly even Marx³. In this thesis we take the view that theories, if they do not obviously imply normative conclusions (conclusions about how we ought to act), at least delineate the area in which action may take place. This is intended to be a fairly weak account of the role of theory, because we wish to avoid the difficulties inherent in some strong accounts of the role of theory, especially those difficulties that might be said to derive from 'constructionist' schools of thought, where such things as 'facts' (and 'truths') have no reality outside of the particular theory in which they are embedded. We do, however, accept that theories play a role in organising facts. The example that Popper gives in his Conjectures and Refutations illustrates the point that without some structure knowledge would be impossible⁴, but the point is (and this is intended to count against the constructionists) that the world itself provides a structure. We may illustrate what we mean by this with reference to the Kantian distinction between the phenomenal world and the noumenal world.

For Kant, the human mind can have access only to the world of phenomena, the world, that is, of appearances. The noumenal world (the world of the

-
3. See, for example, Marx's letter to his father of 10th November, 1837, in David McLellan (Ed.), Karl Marx Selected Writings, (Oxford: Oxford University Press, 1977), pp.5-9, where Marx indicates that the opposition of 'is' and 'ought' - a 'hallmark of idealism' - might be overcome by a materialist philosophy.
 4. In order to illustrate the absurdity of the belief that scientific investigation proceeds from observation to theory, Popper asked a group of students to whom he was lecturing to 'Take pencil and paper; carefully observe, and write down what you have observed'. Popper, of course, had not specified to his students what it was he wanted them to observe. Related by Popper in Conjectures and Refutations, Fourth edition, (London: Routledge and Kegan Paul, 1972), p.46

'thing-in-itself') is inaccessible to the human mind, although it can be inferred (by any rational mind) through our experience of the phenomenal world. In other words, we can only ever know the appearance of an object, and never the object in itself. Although the noumenal world is sometimes taken to be the world of ideas it should not be confused with the Platonic realm of the forms, where an actual object - for example, a chair - approximates to an ideal 'chair'. The noumenal world for Kant is inaccessible to experience; it is unknowable since that which is knowable, for Kant, must be phenomenal⁵. Now, admittedly this is a crude caricature of Kant's theory of knowledge, but it would require a separate work (and probably several of those) adequately to do it justice. However, the point we wish to make is essentially straightforward. The question arises for Kant as to the nature of the relationship that might exist between the two worlds. When Kant suggests that we can only know the appearance of an object, and never the object in itself, he seems to be suggesting that the categories we, as human beings, impose on the world enable us to make sense of what is essentially shapeless and formless (since the categories of dimension - space, time, etc. - are applied to the phenomenal world by beings with our particular mental capacities). Quite how we are to understand the notion of something transcendental (the noumenal thing-in-itself) inhering in phenomenal objects is unclear. But what seems to be certain is that if there is indeed a relationship between the two worlds (and it must be said that the very idea of 'relationship' would seem to belong to the phenomenal world, unless we wish to see Kant - as Marx saw him - as a mere idealist) then the noumenal world itself must be ordered in

5. One may reasonably make the objection that, since Kant claims to know about the existence of the noumenal world, it too has entered his experience and has become phenomenal.

some correspondence with the phenomenal world. If this were not so, there would be no relationship between the two worlds. The noumenal world, in its shapelessness and formlessness, would be arbitrary so that there would be no things-in-themselves (because the notion of 'things' and 'selves' would be meaningless). If this were the case, then the 'appearances' we experience in the phenomenal world would have to originate with us, and if there were no correspondence between the noumenal and the phenomenal worlds we ought to be able to construct whatever phenomenon we wish to 'see'. This is as a short route to the most radical kind of idealism - solipsism - and if it is to be avoided, then Kant himself must accept that the noumenal world constrains, in some sense, what may exist in the phenomenal world⁶.

The point of this discussion is to suggest that, although we may require theories in order to understand the world, we must take it that the world is 'given'. David Hume's notion of causality also bears this out (and Kant, of course, saw his own theory of knowledge as in part an attempt to answer problems raised by Hume), for although Hume also believed that human beings impose relational concepts upon the world, he nevertheless believed that those events to which concepts were applied had independent existence. Relationships of causality were a human imposition on objects that were nevertheless constantly conjoined. Theories, we may say, enable us to organise empirical data, but there must be empirical data for theories to work on, and the way the world is will constrain the theories that we have about it. This does not mean

6. This seems to be Roger Scruton's understanding of Kant's account of the relationship between the two worlds. Scruton, Kant, (Oxford: Oxford University Press, 1982), p.45, where he suggests that the concept of the noumenon marks out the limits of experience.

that there cannot be a variety of ways of organising empirical data, but it does mean that the theories do not and cannot create that empirical data. This would be to put the cart before the horse. Popper could suggest to his students that they observe, say, light-fittings, but he could not, by suggesting this, make them 'see' light-fittings that did not exist⁷.

In terms of political theory, one aspect of the world assumes some importance, at least within the terms of this thesis. This is the social context within which individuals may be said to operate, or, more precisely, the 'social forms' (as Raz calls them) or 'forms of life' (as Wittgenstein calls them) that individuals engage with. If we are to begin to understand the individual in relation to his or her social milieu, then, as Wittgenstein suggests, we must take 'forms of life' as given⁸. This might be thought to align us with certain 'communitarian' thinkers (Charles Taylor, for example, or Michael Walzer, or possibly even Alasdair MacIntyre), and it is true that our understanding of 'personhood' is mediated, if not through some notion of 'community' then at least through the notion of 'social forms' (or 'forms of life'). We do not, however, take the communitarian notion of 'community' to be equivalent to the notion of a 'social form' discussed in this work. One important reason for this is that we do not attribute to the notion of a 'social form', as we understand it, the normative content that communitarians appear often to attribute to the notion of 'community'.

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7. We recognise that, under certain circumstances, individuals can be made to 'see' things that are not there - for example, under the influence of hallucinatory drugs. We also recognise that one's expectations may lead one to interpret data in a particular, but erroneous, way.
8. Ludwig Wittgenstein, Philosophical Investigations, (Oxford: Blackwell, 1953), para.217

Our concern, as we shall specify shortly, is with a particular aspect of liberal political theory. Our account of 'social forms' is derived from Raz, and serves essentially the same purpose here as it does for this thinker - it overcomes the individualistic, atomistic tendencies to which liberal theory is often said to fall prey.

Communitarian theories have developed, in part at least, as a response to what is undoubtedly a central difficulty of liberal political theory. This difficulty consists in attempting to find a foundation upon which to construct political and social institutions (and, since this is our concern, social policy) given the characteristically liberal view that individuals are best placed to decide for themselves what is the good for them. The communitarian response represents an attempt to come to terms with the apparently foundationless impasse that liberal theory has led to. However, whilst acknowledging the seriousness of this debate, it must be said that our concern in this thesis is not with the question of how well-founded political theories may (or may not) be. Our concern, as we have already suggested, is with the implications of a particular theory concerning what it is to be a person. Our concern, we may say, is with a particular theory of human nature. There are, of course, many accounts of human nature available to political and social theorists⁹. The point of developing such accounts is classically thought to be twofold: first, to delineate what is to be counted as the good life for human beings; and second, having established what this is, to

9. Two models - 'plastic' and 'autonomous' - are discussed by Martin Hollis in his Models of Man, (Cambridge: Cambridge University Press, 1977), pp.1-21. See also Christopher Berry, Human Nature, (London: Macmillan, 1986), passim; and Leslie Stevenson, Seven Theories of Human Nature, (Oxford: Clarendon Press, 1974), passim.

decide what form of society will best attain it¹⁰. In this thesis we shall concentrate on one particular account of what it is to be a human being. We shall refer to this as a 'liberal' account, although we shall not be citing a thinker, or set of thinkers, as the 'authentic voice' of liberal theory (one reason for this is that liberal theory has many 'authentic voices'). Our use of the term 'liberal' is left intentionally vague at this point, and the reason for this is that our interest lies essentially with but one aspect of some liberal accounts of human nature - autonomy. This vagueness, however, begs the question as to why we wish to retain the term 'liberal' at all. One reason for this is to signal that we wish to demarcate our discussion in the text from other issues and theories that might be thought to impinge upon our concerns. We have already suggested that one area of possible concern - that identified by the communitarians - is held to be outside the scope of this thesis. But our concern with autonomy (rather than the classic liberal concern with liberty) might be said to bring other theories within our scope. For example, Marx may be said to have had an account of autonomy at the heart of his political theory - at least in his earlier writings¹¹. However, for Marx autonomy (or self-determination) appears to be a future state, while 'liberal' accounts generally hold that individuals are autonomous (or at least are capable of autonomy) here and now.

Another set of theories that fall outside the scope of this thesis are those broadly described as 'consequentialist'. It is often claimed in the field of moral philosophy that deontological theories are

10. This is clearly expressed in the opening paragraph of Aristotle's Politics, Translated and Introduced by Ernest Barker, (Oxford: Clarendon Press, 1946), p.1

11. See Chapter Three, **section i(b)**, for a discussion of an account of autonomy derived from Marx.

incompatible with consequentialist theories. This is because the former prioritise the rights that individuals are thought to have, while the latter emphasise the importance of impartially maximising the amount of good (however 'good' is to be defined) in the world, a position which (as was the case with Bentham discussed above) might on occasion necessitate over-riding individual rights in the name of some greater good. Deontological (or agent-relative) theories generally hold that individuals are best placed to judge what is the good for them, with the implication that there may be as many accounts of the good as there are individuals. Consequentialist theories, on the other hand, seek an impersonal account of the good, thus raising the possibility that any individual might not agree with this account¹². A criticism frequently made of consequentialist theories is that, in pursuing this impersonal account of the good against individual accounts, they belie an authoritarianism that deontological theories avoid (although not all deontological theories avoid this criticism. Even Kant's ethical theory can be said to place us under the strict authority of universal rational principles).

The connection between deontological theories and moral autonomy is sometimes made through Kant, though this time through his moral theory as set out in his Groundwork of the Metaphysics of Morals which is often taken to be a paradigmatic statement of the deontological position¹³.

12. For a discussion of this debate, see the introductory essay by Samuel Scheffler in Scheffler (Ed.), Consequentialism and Its Critics, (Oxford: Oxford University Press, 1988). See also the debate between J.J.C. Smart and B. Williams, published as Utilitarianism: For and Against, (Cambridge: Cambridge University Press, 1973)

13. Kant's Groundwork... is translated and analysed by H.J. Paton in The Moral Law, (London: Hutchinson University Library, 1941)

For Kant, to be autonomous is to be rational and therefore moral. For Kant, the motive of the moral agent is of paramount importance. The significance of a moral act is to be weighed against the motive of the person performing it, regardless of consequences. For the consequentialist, on the other hand, the moral significance of an act is determined by its consequences regardless of the motive of the agent. However, our interest in this thesis is not with the relatively restricted notion of moral autonomy, but instead with the broader notion of personal autonomy. The reasons for focussing on personal rather than moral autonomy will be made clear in Chapter Two, but to anticipate the argument, we may state here that personal autonomy seems to us to be a much more fundamental concept than moral autonomy. The latter concept is usually a component part of a moral system (Kant's, for example), but of course moral systems may themselves be autonomously chosen, or rejected. We do not therefore accept the Kantian conflation of autonomy with acting morally (as opposed to immorally), since autonomous persons might well choose to act immorally. That moral systems may be autonomously chosen suggests that the choice of moral system is itself not a moral choice, so that personal autonomy may be said to be a prerequisite of morality, and if this is so it cannot itself be a moral concept.

Our task in this thesis is not merely to explore the relationship between moral autonomy and personal autonomy. We are also interested in exploring the practical implications of the account of personal autonomy we seek to develop. We have already noticed (above) that the 'classic' account of the purpose of political and social theory is twofold - initially to develop a theory of the good (or the good life), and then to describe how best to attain this good. But if the task of practical

politics is to secure the good life for all, and each autonomous individual chooses and is responsible for developing his or her own version of the good life, then some means of matching political objectives to individual objectives is required, if the authoritarianism entailed by consequentialist solutions to this problem is to be avoided. One theoretical solution to this problem utilises a reflexive mode of argument, modelled on that employed in H.L.A. Hart's influential essay "Are There Any Natural Rights?"¹⁴. Hart argues that if there are any moral rights at all, then there must be a natural right to freedom, for to assert that there exists an obligation presupposes that those obliged must also possess that right. This form of argument has been used by several writers in the context of political and moral theory, in an attempt to establish the primacy of autonomy over other potentially foundational principles (such as utilitarianism). One such author states the argument in the following terms:

Autonomous persons are capable of planning and deliberation concerning their actions and projects. Unless political theory assumed that persons were autonomous in this sense, there would be no point in taking the trouble to construct such a theory.¹⁵

This type of argument is not without its difficulties. In Hart's case, a straightforward criticism could focus on the conditional nature of the argument, for one may deny that there are such things as moral rights in the first place¹⁶. Similarly, it is possible to deny that persons are

14. H.L.A. Hart, "Are There Any Natural Rights?", in Anthony Quinton (Ed.), Political Philosophy, (Oxford: Oxford University Press, 1967), pp.53-66

15. Albert Weale, Political Theory and Social Policy, (London: Macmillan, 1983), p.45. See also Alan Gewirth, Reason and Morality, (Chicago: University of Chicago Press, 1978); and Raymond Plant, Harry Lesser, Peter Taylor-Gooby, Political Philosophy and Social Welfare, (London: Routledge and Kegan Paul, 1980). The latter is discussed at some length below, in Chapter One, sections iv(b) and v, and Chapter Two, section ii.

16. This possibility is recognised by Hart, ibid., p.54

'capable of planning and deliberation concerning their actions', since this view rests on the implicit assumption that the central characteristics of human nature comprise of 'purposive action, self-control and self-development'¹⁷. An alternative account of human nature will then conceivably undermine the reflexive argument in favour of autonomy. For example, in a mechanistic universe where there is little or no room for free will, one would expect there to be little or no room for self-control. However, it is not our task here to enter into the complex and unresolved philosophical debate surrounding the notions of determinism and free-will¹⁸. Another potential difficulty for autonomy-based theories is presented by the marxist notion of 'false consciousness', where even if one believes oneself to be in control of one's life, one might nevertheless be radically mistaken, one's understanding of oneself being a product of the prevailing ideology¹⁹. The 'false consciousness' thesis, with its implicit assumption that there is a 'real' consciousness, raises important issues concerning the nature and construction of reality. Such concerns, however, are well beyond the scope of this thesis.

17. Michael Freeden, Rights, (Milton Keynes: Open University Press, 1991), p.45

18. But see Weale's brief discussion of Hobbes with regard to this point, op. cit., pp.46-47. Weale suggests that Hobbes, as thoroughgoing a determinist as one could find, must have assumed some level of autonomy amongst his prospective readership, since in publishing his works he hoped to influence the debates with which he 'chose' to engage.

19. Although this is a marxist position, it is of course disputed as to whether or not Marx himself endorsed it. The term 'false consciousness' is attributed, not to Marx, but to Engels in a letter written to Franz Mehring on 14th July, 1893. For an account of some of the difficulties surrounding the concept, see Ted Benton, "Realism, Power and Objective Interests" in Keith Graham (Ed.), Contemporary Political Philosophy: Radical Studies, (Cambridge: Cambridge University Press, 1982), pp.7-33

ii. The Thesis Stated

In Chapter One, **section i** we examine some of the accounts that are given by political and social theorists of society, and of the kinds of individuals that make up society. Such accounts will, it is argued, influence the way in which both political theory and social policy are constructed. In **section ii** we examine the notion of social policy, characterising it by focussing on the objectives at which social policy is said to aim. Since there are many such objectives and they are not always compatible, one task of the political or social theorist is to find some means of arbitrating amongst them. One way in which this might be done would be to find a single, foundational 'organising principle' or objective that would perform this function. In **section iii** we examine the adequacy for this task of two of the more important objectives at which social policy is said to aim - the alleviation of need, and the securing of liberty. Neither convincingly withstands scrutiny as an organising principle because each requires a separate and additional theory in order to establish a priority of certain needs and liberties over others. In **section iv** we consider two theories of this type - Rawls' neo-Kantian argument, set out in his A Theory of Justice, and that offered by Raymond Plant, Harry Lesser and Peter Taylor-Gooby in their joint work Political Philosophy and Social Welfare. Although both theories have an account of autonomy at their centre, the Kantian formality of Rawls is shown to be too abstract to provide a substantive foundation upon which to construct social policy. Plant et al's theory is also shown to be inadequate, but encounters fewer difficulties than Rawls'. In **section v** we consider some problems with the concept of moral autonomy employed in both of these works. It is argued that, at least for the purposes of deriving substantive policy proposals, the concept

of moral autonomy ought to be replaced by the more promising concept of personal autonomy. In **section vi**, the final part of this chapter, the substantive nature of personal autonomy is indicated through its relationship to the notion of a plan of life.

Chapter Two explores in greater detail some of the issues raised in the previous chapter. The first section of this chapter considers the 'neutrality' of autonomy. Taking personal, rather than moral, autonomy as the focal point, the discussion in **section i** considers the problem of neutrality in respect to two important recent political theories - that of John Rawls, aspects of whose A Theory of Justice we will have already discussed (albeit in a different context and for different reasons) in Chapter One, and Robert Nozick's Anarchy, State, and Utopia. In **section ii** we identify an important ambiguity in Plant et al's account of autonomy, and its relationship to morality. The importance of this ambiguity rests on the moralistic account of autonomy given by the authors. In **section iii** the relationship between personal and moral autonomy is examined in some detail, through a discussion of Joseph Raz's The Morality of Freedom. The point of this is to establish the priority of personal autonomy over moral autonomy. But if personal autonomy is to be an 'organising principle' for social policy, then we must be in a position to substantiate the concept if we are to avoid the problems of conceptual formality that adhere to the Kantian notion of moral autonomy. For this reason, and in the final two sections of this chapter, we make some attempt to contextualise our account of personal autonomy. **Section iv** examines Raz's notion of a 'social form', and how this is to be related to his account of personal autonomy. But Raz's account of personal autonomy is itself confused, and his account of what

a 'social form' consists of is shown to be vague. **Section v** offers some tentative clarification of the latter concept, and of its relation to the former.

In relating our account of personal autonomy to social forms, we seek to overcome the individualist tendencies of much liberal theory. This has practical import if we seek to make practical use of our account of personal autonomy in the formation of social policy. In Chapter Three therefore, we continue the task of contextualising personal autonomy. In the **section i** of this chapter, this project is pursued through an attempt to situate the concept of autonomy in relation to a tradition of political thought and practice - liberal democracy. This is intended to show that adoption of autonomy as a focal point for social policy would not be a revolutionary project. In order to demonstrate this, we distinguish our account of autonomy, centred as it is on a liberal tradition, from what might reasonably be said to be an account of autonomy with revolutionary implications. This is the marxist tradition. In **section ii** we examine the relationship between autonomy and liberty. Classically, of course, a concern with liberty is taken to be a central characteristic of liberal theory. However, our account of the liberal tradition prioritises autonomy. In **section ii** of this chapter, therefore, we attempt to clarify the relationship between liberty and autonomy in the context of a discussion of Berlin's account of positive liberty. In **section iii** we examine the notion of independence in relation to our account of personal autonomy, and in **section iv** we examine the relationship between autonomy and rationality. The problem that we identify in relation to both independence and rationality is the tendency, inherent in liberal theory, to view individuals as atomised,

self-contained units. Against this we contend that the very idea of 'personhood' must, if it is to be intelligible, make reference to a context, or situation, beyond 'ruggedly' independent or rational beings. In **section v** we argue, against 'intellectualist' accounts of autonomy, that the autonomous person must be viewed as a totality, or, what amounts to the same thing, that autonomy must be seen as embodied in material persons. This materialist account of autonomy is intended to avoid the idealist associations that some post-Kantian accounts might entail. We argue that the body is the primary means of enacting one's autonomous decisions, so that the condition - or health - of the body assumes some importance, not only for those who are thought to be autonomous, but also for those who are charged with the task of formulating social policy. The final section of this chapter - **section vi** - considers some initial difficulties in relating the notion of health to social policy, through autonomy.

Having established the importance of health to our account of autonomy, we then move on, in the final two chapters of the thesis, to discuss some of the implications of our account. Chapter Four examines a set of sociological theories that pose a potential difficulty for accounts of autonomy that focus on health. These all turn on the phenomenon of medicalization which is taken to be a process whereby the power, influence, or authority (or all of these) of the medical profession expands at the cost of individual autonomy. Theories of medicalization may be grouped into three categories. The first of these suggest that the rationale underlying the expansion of medical influence in society is professional self-interest. This self-interest largely manifests itself in two ways. First, it takes the form of a defence, by the

profession, of its scientific status. This offers the profession a means by which it may secure funding for itself while simultaneously enabling it to exclude rival medical practices. The effects of this are seen to be ambiguous with regard to autonomy. There is, for example, no doubt that having adequate choices is an important component of autonomy, and choice of treatment (where, for example, 'alternative' medicines are included in the range of health care on offer) might therefore be thought important to autonomy. But the question arises as to where, and how, one is to draw the line between medicine and quackery. The second manifestation of self-interest turns on the use that the medical profession makes of technology. This too has its ambiguities, since the medicalization that occurs may be said to be a 'spin-off', an unintended consequence, of the imposition of technology the point of which, after all, is to secure a benefit to the patient.

Section ii examines the second category of medicalization - where it is viewed as part of a wider social process - through a discussion of the theories of Ivan Illich and Vicente Navarro. Illich's account is seriously flawed, because his view of what it is to be autonomous is inadequate, bearing, as it does, the hallmarks of the individualist accounts rejected in Chapter Three. Navarro's account locates the source of medicalization in the capitalist structure of western industrial society. His is a self-consciously marxist account, where medicalization is a form of alienation, and as such its terms of reference, strictly speaking, fall outside the scope of this essay. All the same, some tentative criticisms are levelled at the theory.

In the final part of this chapter, **section iii**, we consider the argument that medicalization is a form of social control. In particular, we focus on the work of Talcott Parsons, whose concept of deviancy derived from a Durkheimian theory of role-occupancy. Sickness, for Parsons, is potentially a form of deviancy, since it could prevent individuals from filling the role (or roles) that the social structure has allocated to them. Social order is to be maintained, according to Parsons, by the sick person correctly filling the 'sick role', allocated to him, or her, by the medical profession. It follows from this that, in a Parsonian world, the medical profession is an important agent of social control. There are serious difficulties with the Parsonian account of the social structure, and the most serious of these arises out of his account of role-governed behaviour. The Parsonian idea of 'role-occupancy', for example, bears no relation to the notion of 'social forms' developed in Chapter Two of this thesis, since it is, or appears to be, rigidly deterministic, and in a deterministic universe, there is no room for autonomy, personal or otherwise.

We began, in Chapter One, by suggesting that a particular account of personal autonomy might provide an organizing principle around which social policy might be constructed. In Chapter Two, we explored this concept of autonomy, linking it to a social context through an account of social forms. In Chapter Three we placed our account of autonomy in an historical context, and then went on to argue that our account of autonomy required us to view individuals as whole persons. This in turn required us to acknowledge the importance of the body, and hence of health, to our account of autonomy, and so to social policy. In Chapter Four we examined the relevance to our argument of three accounts of

medicalization. In our final chapter, Chapter Five, we consider the relevance to our account of autonomy of an aspect of health policy that focusses on the responsibility of the individual - preventive health-care. What is of primary interest in the ensuing discussion is what kind of individual it is that preventive health-care policy assumes. Health-care policy is, of course, a vast and diffuse subject - this is one reason why we choose to consider but one aspect of it. But in order to fix our discussion still further we consider a particular approach to preventive health-care as it was set out in a series of documents published by the British government under the Prevention and Health rubric, between 1976 and 1981.

Although this series of documents was published by the British government, the general approach to preventive health-care that they adopt was not itself unique to Great Britain²⁰. For this reason, of course, our comments, although focussed on a set of British publications, might be expected to have wider application than within these shores. However, this is not something we pursue in the text. We also do not pursue the reasons for the relatively sudden and widespread interest amongst nations in prevention although there were a number of these - rising medical costs and so rising public expenditure; the changing disease-profile of modern industrial society and the replacement of the traditionally endemic diseases with the so-called 'diseases of affluence' (cancer; heart disease) for which there existed no effective cure and against which the medical profession was therefore

20. The key document in the rise in interest concerning preventive medicine is Marc Lalonde, A New Perspective on the Health of Canadians: A Working Document, (Ottawa: Department of National Health and Welfare, 1974). All the hallmarks of the British prevention campaign are to be found in this document.

largely powerless; the realisation that medical intervention could itself damage patients.

We begin in **section i** with a discussion of the very idea of prevention, where we seek to demonstrate some of the complexities of what initially appears to be a relatively straightforward concept. The central difficulty turns on the notion of a 'problem state' - that which is to be prevented - since there are both subjective and objective dimensions to be considered. The idea of a problem state itself makes reference to 'norms' of various kinds - behavioural norms, health norms, and so on - which also have subjective and objective aspects²¹. Once a problem has been identified there may be a choice of preventive strategies available to those charged with solving it. In **section ii**, we discuss some of the difficulties that might hamper preventive strategies, especially the 'dilemmas of uncertainty' that might themselves prevent the implementation of preventive policies. In **section iii** we look in some detail at the concept of prevention employed in the **Prevention and Health** campaign, and consider some of the implications of adopting this particular account of prevention, rather than any other. A stated aim of the **Prevention and Health** campaign was to make clear to average non-medically trained persons the responsibility that devolved to them for the state of their own health. It is suggested that utilising this particular account of prevention allocates responsibility for a variety of preventive functions in a way that implicitly supports this project. In **section iv** some of the implications of this account of responsibility are drawn out through a discussion of the model of disease-causality

21. In making these problems explicit, of course, we do not solve them, but acknowledging that there are problems is a prerequisite of solving them.

that is said characteristically to underpin individually-focussed preventive policies. Since the model of disease-causality employed appears to treat of individuals in the fashion said to be characteristic of liberal theory (i.e. atomised), it follows that this approach to preventive health-care would be incompatible with an attempt to utilise our 'holistic' account of personal autonomy as an organising principle, at least with regard to this aspect of health policy.

Preventive health-care, of course, is but one aspect of a vast and complex health-care industry, and the **Prevention and Health** campaign represented only a relatively small (and short-lived) government-sponsored exercise within that industry. It might be thought to follow from this that we may draw only modest conclusions from our examination of this campaign. But in the context of our general discussion of personal autonomy this need need not be the case. In our conclusion then, we seek to indicate that the consequences of taking our account of personal autonomy seriously as an organising principle for social policy might potentially have radical implications.

Chapter I: Social Policy and Autonomy

I.i: The Nature of Social Policy

Social policies presuppose the existence of society. This, after all, is what makes them social policies. But the nature of society is in dispute, and if we are to understand what social policy is and why social policies take the form (and have the content) that they do we must begin by addressing the disputes that hinge on our understanding of the nature of society. This has practical as well as theoretical importance, for such disputes are not confined to the realms of academia, or even to the more restricted sphere of the social sciences. The claim that society is a 'fiction' may well be found in the theoretical writings of the eighteenth-century legal theorist Jeremy Bentham¹, but it is also a claim recently restated by the then leader of the British Conservative Party - Margaret Thatcher. If we are to understand social policy adequately, we must address at least some of the problems - theoretical and practical - that are associated with the notion of society. We begin, therefore, with an account of some of the theoretical problems concerning the concept of society.

(a) Individualist Accounts of Society

Accounts of society may be (and conventionally are) ranged along a continuum. Society may be defined at one end by reference to the individuals that comprise it, such that there are no statements about society that are not directly reducible to statements about the individual members that are thought to make up that society. This position is associated not only with Bentham, but also with Hobbes,

1. Jeremy Bentham, The Principles of Morals and Legislation, (New York: Prometheus Books, 1988), Ch.I, para.IV, p.3

Montesquieu, J. S. Mill, and, more recently, with Friederich Hayek and Karl Popper². From this initial premise, and the further assumption that individuals are the best judges of their own interests, it is sometimes deduced that state intervention in the activities of individuals ought to be kept to a minimum³. On these grounds it is concluded that the appropriate regulating principle governing the distribution of goods throughout society ought to be the market. This is thought to be preferable to state regulation because the market, and the benefits contingent upon the operation of that market, are taken to be the result of choices made freely and voluntarily by participants, in the absence of coercion. From this perspective, the role of social policy will be residual, clearing up those areas of concern with which market mechanisms cannot cope or are held to be inappropriate⁴. On this view, the state (whatever is to be understood by this term) need not simply confine itself to the policing of the voluntary exchanges made in the market-place, or to the protection of property legitimately obtained there. For example, it would seem to be admissible within the terms of this model for the state to adopt a progressive role in those areas where market mechanisms either could not cope, or would not be

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2. Steven Lukes, "Methodological Individualism Reconsidered" in Alan Ryan (Ed.), The Philosophy of Social Explanation, (Oxford: OUP, 1973), pp.119-124 for an account of the methodology associated with this position. For an account of the dangers said to be inherent in seeing society as something more than the sum of its parts, see F.A. Hayek, "What Is 'Social' - What Does It Mean?" in Albert Hunold (Ed.), Freedom and Serfdom, (Dordrecht: D. Reidel, 1961), pp.107-118
 3. This is not universally concluded by methodological individualists, of course. Hobbes, for example, argued for substantial intervention by the state (or, more correctly, by the Sovereign) in the activities of its individual members. Bentham himself, in his posthumously published Constitutional Code, (1843), prescribed extensive governmental powers of intervention and regulation. See Bill Jordan, The State: Authority and Autonomy, (Oxford: Basil Blackwell, 1985), p.64
 4. Richard Titmuss makes this point in Social Policy, (London: George Allen & Unwin, 1974), pp.33-34

appropriate. So we find that in the heyday of laissez-faire capitalism, Edwin Chadwick (himself a Benthamite utilitarian) proposed and instigated a programme of interventionist sanitary reform which, had it been left to individual choice and action, would not have developed when it did, if at all. With the exception of only the most radical of libertarians, few would deny that the state had no role to play in the distribution of goods, especially collective goods where little or no incentive exists for individuals qua individuals to act. Similar arguments may be made with regard to education⁵ and the defence of the country⁶. Aspects of health care may also require non-market solutions⁷. Markets, to use Halevy's terminology, exist to harmonize naturally the interests of the participants, but where markets are inappropriate or inefficient the state may provide an artificial means of harmonization.

(b) Holistic Accounts of Society

At the other end of the continuum there is the view that individuals cannot be understood without reference to society because society makes individuals what they are. This view is often attributed to G.W.F. Hegel, for whom it is said individuals are but contingent aspects of the Absolute, and for whom 'concrete' freedom consists in subordination to

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5. Bill Jordan, Rethinking Welfare, (Oxford: Basil Blackwell, 1987), p.39
 6. Market solutions may raise the problem of the free-rider. Some people may be willing to contribute to the defence of their country, while others may not. The latter will still benefit from civil defence while contributing nothing to its upkeep. Non-market solutions, in this case government supply of defence from taxation, ensure equity.
 7. Health insurance, for example, is notoriously difficult to obtain for those suffering from terminal illnesses. This is one argument in favour of a national insurance scheme which is blind to the nature of a person's illness, or state of health.

the State⁸. It is also possible to attribute a similar position to Marx (whose intellectual debt to Hegel ought not to be underestimated). For Marx, the very notion of the 'individual' can be said to be but a function of historically specific social relations, characterised by class conflict⁹. In the context of social policy, the problem here is that if the notion of the individual is debased, then the notion of individual interests, desires, needs and so on is also potentially called into question. If interests, desires, needs, and so on are generated by one's position either in the order of things (for Hegel) or in the class struggle (for Marx) then the special status accorded to these by the free-market model is diminished. Since interests, desires, needs and so on are no longer things that originate in the subject, the subject might not necessarily be the best judge of what they are. It devolves then to philosophers, intellectuals, or politicians to discern what is in a person's interest. Social policy, on this reading, might become something that is imposed by an external source and possibly in direct contradiction to the subject's perception of his or her own interests¹⁰.

8. G.W.F. Hegel, Philosophy of Right, Translated by T.M. Knox, (Oxford: Clarendon Press, 1952), paras.182-186 for example.

9. At least this much may be inferred from the "Economic and Philosophic Manuscripts" of 1844, where Marx discusses the concept of 'species-being' and remarks that 'it is above all necessary to avoid restoring society as a fixed abstraction opposed to the individual. The individual is the social being', in D. McLellan (Ed.), Karl Marx Selected Writings, (Oxford: Oxford University Press, 1977), p.91. This point is echoed in the sixth of the "Theses on Feuerbach" (from whom Marx derived the concept of 'species-being') where Marx describes the human essence as 'the ensemble of social relations', in McLellan, op. cit., p.157

10. It must be said that adherents to the individualist account of society sometimes argue that individuals are not always best-placed to judge what is in their interest. Bentham's supporters, for example, distinguished between 'real' and 'apparent' interests in their defence, against Macaulay's attack, of James Mill's Essay on Government. See Lively; Rees (Eds.), Utilitarian Logic and Politics, (Oxford: Clarendon Press, 1978), pp.46-48

(c) Human Nature and Political Theory

A further theoretical difficulty, and one which closely parallels the difficulties discussed with reference to society, concerns the nature of those individuals who comprise society. It has been suggested that prescriptive political theories rest on, often implicit, assumptions or theories about human nature¹¹. These theories may take a variety of forms and may have various implications for social policy. For Hobbes, it is the fear of death and the subsequent pursuit of instrumental power in order to avoid this calamity that is characteristic of all human beings, a 'general inclination of all mankind' as he puts it¹². The social policies (if they may be described as such) that Hobbes claims to deduce from this account of human nature include measures that would not be out of place in a modern welfare state¹³, but also include measures (such as the all-powerful Sovereign) which would generally be held to be unacceptable. Alternatively, Marx's account of human nature, as it is set out in the **Economic and Philosophic Manuscripts** of 1844 generates a quite different attitude to welfarist policies. Given the relationship that is there said to exist between the worker, the object of production, and the capitalist, it is unlikely that a programme of pragmatic social reform will do very much to overcome the alienation experienced in work which is both repetitive and mundane. Different accounts of human nature will lead to differing views as to the kinds of social policy that will be appropriate in any given context. But the account of human nature one gives may serve another objective with

11. Christopher Berry, **Human Nature**, (London: Macmillan, 1986), pp.1-28; Alasdair MacIntyre, **A Short History of Ethics**, (London: Routledge and Kegan Paul, 1967), p.268

12. Thomas Hobbes, **Leviathan**, Edited by C.B. MacPherson, (Harmondsworth: Penguin Books, 1981), p.161

13. Hobbes, **op. cit.**, p.387

regard to social policy. For accounts of human nature are not only employed in the construction of social policies; they might also be used to criticise existing social policies. This is certainly true of those 'New Right' theorists who argue that socialism, or at least those policies pursued by the British Labour Party since 1945, has repressed or distorted the development of human potentiality through the creation of a 'culture of dependence'. The 'enterprise culture' is intended not only to raise living standards throughout society by regenerating the economy and so on, but also to re-moralize the population through the creation of self-reliant, responsible and altruistic citizens. Where it is sometimes held to be a strength of conservative thinking that it has no dogmatically-held view of human nature, and thus that it avoids the totalitarian implications of 'utopian' or 'end-state' theories, this betrays an account of human nature which is both substantive and teleological¹⁴.

We have so far attempted to establish two things: first, that there is a variety of ways in which society, and those individuals of whom it is composed, may be understood; and second, that the account one holds of these two entities and of the relationship between them will have some bearing on the kinds of social policies proposed. In the next section we examine the idea of social policy, before, in the final three sections of this chapter, examining the connection between social policy and personal autonomy.

14. Ian Carter, "Human Nature and the Utopianism of the New Right" in Politics, (1989), Vol.9(2), p.5

I.ii: Social Policy and Value

The term 'social policy', as T.H. Marshall has pointed out, eludes precise definition¹⁵. One way in which a definition might be arrived at would be to see what kinds of things are generally taken to be social policies, as distinct from, for example, economic policies. Marshall suggests that, conventionally at least, social policy concerns itself with those things related to the maintenance of social security - maintaining, that is, a standard of living during periods of sickness, unemployment, and old age. Social policies could then be said to provide a system of benefits and services geared to the maintenance of a standard of living, or of a particular level of welfare¹⁶. But the implementation and administration of social policy costs money. It might therefore, and with some justification, be argued that economic policy is itself a form of social policy, albeit an indirect one¹⁷. But it might equally be argued that economic policy is a constraint on social policy. The Thatcher-led Conservative government, for example, can be said to have utilised 'monetarist' economic policies during the 1980s to rein in what they took to be an over-extension of governmental ability to finance social policy to the detriment of the country's economic,

15. T.H. Marshall, Social Policy, 5th Edition, Revised and Edited by A.M. Rees, (London: Hutchinson, 1985), p.11

16. As Richard Titmuss has pointed out, there are numerous examples of social policy which do not seem beneficent or welfare-oriented. Hitler's social policies concerning Jews, Homosexuals, and the mentally ill and retarded, for example, prompt one to ask 'whose welfare?' or 'whose benefit?' does social policy serve? 'What is welfare for some', says Titmuss, 'may be "illfare" for others'. Titmuss, op. cit., pp.26-27

17. Marshall suggests that social policy is distinct from economic policy in that the former is concerned with individuals in an immediate sense, whereas the latter is concerned with the welfare of society as a whole. The suggestion, presumably, is that the latter, in raising the level of welfare of society, may do so at the cost of some individuals or groups. Marshall, op. cit., p.15

entrepreneurial health¹⁸. A positivistic definition of social policy indicates an international (but not universal) acceptance that the state has some responsibility for at least the social security of its citizens¹⁹. But positivist accounts of social policy do not indicate why, at other than a superficial level, social policy differs from country to country and, within a given country, from time to time. An alternative way to state this problem is to ask how social values change over time, and how they come to differ from country to country. This question might be answered by adopting an historical perspective. This would involve specifying the particular traditions of thought that are characteristic of a particular society (leaving aside the problem of what constitutes a 'tradition'). For if theories of human nature and of the nature of society underpin social policy, then we would expect to be able to locate social policies in traditions of thought²⁰, or we should at least to be able to say something of the relationship between these traditions and social policy. This in turn requires us to say something about the way in which value gets built into social policy, for if it is the case that political theory aims at specifying the Good for human beings then we might expect social policies to embody the the values deriving from this specification.

18. Ian Gough, "Thatcherism and the Welfare State" in Stuart Hall; Martin Jacques (Eds.), The Politics of Thatcherism, (London: Lawrence and Wishart, 1983), pp.151-153

19. Marshall, op. cit., p.11

20. This point, with regard to autonomy, will be returned to in Chapter Three, **section i**, below pp.106-114.

An obvious and salient criticism of this project would be to accuse us of overstating the importance of political theory to the essentially pragmatic task of formulating and implementing social policy.

Totalitarian societies apart, social policies are never solely the work of one person, or party. On the contrary, they usually represent the result of complex negotiations between Ministers, junior ministers, civil servants, select committees, lobby groups, pressure groups, other government departments, and sometimes the mass media²¹. The resulting social policy might then represent some consensus or compromise as to which objectives are to be pursued by which means. Even within political parties, where political theory might be thought to be of singular importance, it is not always clear which political theory best characterises a party - for example, both high Tories and low Tories will be found inside the Conservative Party. But although this criticism is both salient and important, it need not concern us here. Our project here requires us only to take seriously the claim that our own society (since this is the focus of the analysis) may be described as a 'liberal democracy'. This term can be left unexamined for the present (though we shall return to it in Chapter Three, **section i** below).

If the positivist attempt to define social policy is unsatisfactory, what alternatives have we? One possibility is to define social policy, not by its content, but instead by its objectives, by the ends at which

21. The complexity of policy-making in the field of health policy is indicated by the fact that over 1,200 organisations gave evidence to the 1976-79 Royal Commission on the National Health Service. G. Jordan and J. Richardson, "The British Policy Style or the Logic of Negotiation" in J. Richardson (Ed.), Policy Styles in Western Europe, (London: Allen & Unwin, 1981), p.90. On the influence of the media in policy-making, see Christopher Ham, Health Policy in Britain, 2nd Edition, (London: Macmillan, 1985), pp.24-25.

it aims, rather than the means - economic or otherwise - used to attain those ends. This is not easy to do because there is dispute as to what these objectives are, or should be. Liberty (or alternatively freedom of choice), equality (or the redistribution of resources), the alleviation of need, dimensions of welfare (individual or social), have all been proposed by commentators on social policy²². The objectives towards which social policies are directed may themselves be a constraint on the kinds of policies adopted. It is sometimes thought to be the case, for example, that equality can be promoted only at the expense of liberty, and that policies designed to distribute resources to promote equality will inevitably be coercive²³. But there is no reason to conclude that social policy should have only one objective, or that a variety of objectives need necessarily be incompatible. For example, enhanced liberty may be thought to be an important component of welfare.

Defining social policy in this way forces us to confront the existence, at the heart of social policy, of value. The problem is that this suggests that debate about social policy must necessarily be inconclusive and there are, it has been suggested, two broad reasons why this should be so. The first is that people can disagree as to which features of a social situation are important as objects of social policy²⁴. There appears to be no self-evident logical reason, for example, why society should choose to alleviate hunger rather than allow the hungry to die. There might, of course, be moral reasons as to why

22. Nicholas Deakin, The Politics of Welfare, (London: Methuen, 1987), pp.15-25; Albert Weale, Political Theory and Social Policy, (London: Macmillan, 1983), pp.4-5; Titmuss, op. cit., p.29

23. Deakin, op. cit., p.19

24. Raymond Plant; Harry Lesser; Peter Taylor-Gooby, Political Philosophy and Social Welfare, (London: Routledge & Kegan Paul, 1980), p.122

one option is preferable to the other, but the status of the moral system one adopts might itself lack a rational or logical foundation²⁵. The second reason why it is said that social policy debate must be inconclusive concerns the status of the principle or theory used to organise the facts or data employed there. If our account of social policy is not to become circular or regressive, we must, it is claimed, have a starting point, a principle of organization. This starting point must be theoretical (since it is the basis upon which empirical data are to be organised) and basic (that is, there must be no further appeal to premises in support of the organizing principle, otherwise an infinite regress would beckon)²⁶. The claim made here is not that associated with the constructionist school of thought, whose adherents claim (crudely, at any rate) that reality is a fabrication and that no fact exists in a purely objective sense²⁷. It is not denied here that there are such things as facts. It is, for instance, a fact that, starved of food and water, a human being will die. But it is not a fact in quite the same way that human beings, or societies, have a duty to alleviate starvation, or remove inequality, or maximise freedom. The problem for social policy is that the duties with which social policy accords, the objectives at which social policy aims, might ultimately be without foundation. And if this is the case, then there may be no ultimately satisfactory way of deciding, of a range of possible policy objectives, which one or set ought to be pursued. Within the terms of this thesis,

25. Emotivists claim, for example, that morality is a question of taste and it is clearly true that tastes differ. Emotivists may be wrong about the nature of morality, of course, but it is certainly true that moral systems differ and even conflict.

26. Plant et al, op. cit., p.122

27. This seems to be the position held by the French historian of ideas, Michel Foucault. See, for example, "Space, Knowledge, and Power" in Paul Rabinow (Ed.), The Foucault Reader, (Harmondsworth: Penguin Books, 1986), p.247

of course, the ultimate boundary of explanation is the term 'liberal democracy' and its corresponding traditions of thought. We recognise, of course, that the justificatory and explanatory use of traditions is itself open to serious criticism, but such criticisms are beyond the scope of this thesis.

Our concern here is to explore, within the terms we have stipulated, the possibility of developing an organizing principle which would provide either a foundation for social policy (such that it would clearly indicate the primary objectives of social policy) or (where there exist several candidates) a means by which an ordering of objectives might be arrived at. We shall begin this exploration with a discussion of two of the most important objectives (the alleviation of need, and the securing of liberty) at which social policy has been said to aim, in order to establish two things. First, where values enter into claims made in the name of these objectives, and second, the extent to which they may be said to provide a firm and privileged foundation for policies designed to achieve them. We examine first the concept of need, then of liberty, before turning to a discussion of two alternative approaches to grounding social policy.

I.iii: Value and the Objectives of Social Policy

Need and liberty are not, of course, the only possible objectives of social policy and it may be that some other candidate might succeed where these fail (equality, utility, and welfare are possible alternatives). The advantage of focussing on these two objectives is that they present us with what might be described as test-cases, since both need and liberty are generally held to be amongst the most important objectives of social policy (for reasons which will be made clear). If it can be established that these two objectives are inadequate for the task of organizing social policy, or of providing a foundation upon which to build social policy, then we may, in view of the limited space available to us, assume (however contentiously) that the alternatives will also be inadequate.

(a) The Alleviation of Need

It has been stated that the single most important purpose of social policy is the alleviation of need²⁸. The concept of need, for example, has been described as 'absolutely fundamental to the understanding of contemporary social policy and the welfare state'²⁹. But the existence of needs in itself is not an adequate explanation for the existence of social policy, for everybody has needs, from the fisherman who needs a rod and line in order to pursue his hobby, to the cancer patient who needs an operation to save her life. The question is, given the vast range of possible candidates, what kinds of needs are to be admissible

28. Jonathan Bradshaw, "The Concept of Social Need" in New Society, 30th March, 1972, p.640. Of course, need is in practice not the only distributive principle employed in welfare legislation. Mothers receive child benefit whether they need it or not. An alternative account of social policy, then, might see it as a response to a right.

29. Plant et al, op. cit., p.20

as objects of social policy? To answer this question, it is useful to consider the structure of need-statements. Need is a relational concept so that statements concerning needs have the following structure (a structure, incidentally, that they share with want-statements):

X needs Y for Z

In terms of policy the need (Y) is judged to be of social concern in the light of the ground (Z) upon which the need arises. It is at the point where judgement occurs as to the worth of Z that value, and also the possibility of conflict, enters the equation³⁰. Why is a person's need for an operation thought worthy of the attention of society, and not his or her need for a fishing-rod? Some means of accounting for treating some objectives as worthy of serious social concern over others is required.

One solution here might be to posit a set of basic needs. Consider the following passage:

But individuals have certain basic needs that arise irrespective of their roles in production or the domestic system, needs which might therefore form part of the substance of equality that makes up the terms of membership of society as a whole. We all need food, shelter, warmth, light and clothes for physical survival. We also need instruction and information to understand the world. We are all vulnerable to illness and injury and during infancy, and so need special attention when we are very young, sick or wounded; and we are all mortal, and can expect to be frail as we approach death. These are common shared needs, which are part of the human condition.³¹

It may indeed be the case that these needs are common to all human beings, but it does not explain why society as a whole should be expected to ensure that these needs are met. What would seem to be

30. Plant *et al*, *ibid*.

31. Bill Jordan, Rethinking Welfare, (Oxford: Basil Blackwell, 1987), p.86

required is some rationale for selecting any particular need or set of needs. One such rationale is implied in the passage quoted above, that of physical survival. Unfortunately, what is not made clear in this brief passage is why human beings alone should be the beneficiaries of social policy. Animals might also be said to have a need to survive and indeed many of the needs specified in the passage are common to other members of the animal kingdom. Dogs and cats need food; horses and sheep are vulnerable to injury; wallabies and bison can expect to be frail as they approach death. Why should society alleviate the needs of human animals on these grounds, while at the same time excluding non-human animals? The move from stipulating a set of basic needs in this way - whether or not they confine themselves to the merely biological (food; drink; sleep; warmth) or include some socially-relative element (health-care; a bed on which to sleep; accommodation as opposed to mere shelter) - must be accompanied by an argument as to what it is about human beings that can be said to create some claim on other human beings (or society), such that their needs ought to be met. The assertion that human beings have needs cannot do the job of providing a foundation for, or justification of, social policy on its own. Let us consider whether liberty fares any better.

(b) The Securing of Liberty

During the past decade, a concern with liberty (or at least with freedom of choice) moved from the margins to the centre of public debate. Previously egalitarian policies came to be viewed as a restraint on personal liberty, fostering a 'dependency culture' and resulting in what was seen to be an increasingly monolithic state. The stated objective of the Conservative Government (then in waiting) was to 'set the people

free'³². But does an appeal to freedom or liberty as a fundamental principle on which to ground social policy fare any better than need? One difficulty here consists in trying to understand what freedom might mean, and hence what the implications might be for social policy. Berlin, for example, suggests that there are two ways in which we might understand freedom - a positive and a negative sense³³, but for now we shall circumvent the debate about negative and positive liberty in order to examine a general and formal claim concerning statements about liberty. According to MacCallum, any statement about freedom will have a tripartite, relational character specifying who (or what, since the agent might be an institution or association rather than an individual³⁴) the agent is who is free; the constraints that the agent is free from; and what the agent is free to do or to become³⁵.

The importance of MacCallum's account of freedom is that it requires us to specify the variables with which we are dealing in discussions of freedom. The advantage for social policy of doing this is that we are then in a position to evaluate the variables, with a view to admitting

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32. The quotation is from Margaret Thatcher's speech to the Conservative Party conference, 1977. Source: Conference Proceeds, 1977, (Conservative Political Centre), p.134. Cited in Frank O'Gorman (Ed.), British Conservatism: Conservative Thought From Peel To Thatcher, (London: Longman, 1986), pp.220-221
33. Isaiah Berlin, "Two Concepts of Liberty" in Four Essays on Liberty, (Oxford: Oxford University Press, 1969), pp.118-172. See Chapter Three **section ii** for a discussion of Berlin.
34. John Rawls makes this point, A Theory of Justice, (Oxford: Clarendon Press, 1972), p.202. See also Lincoln Allison, Right Principles, (Oxford: Basil Blackwell, 1984), p.124
35. Gerald C. MacCallum, "Negative and Positive Liberty" in Laslett; Runciman; Skinner (Eds.), Philosophy, Politics and Society, Fourth Series, (Oxford: Basil Blackwell, 1972), pp.172-193. This is not, as Albert Weale has pointed out, a definition of freedom but an account of the construction of statements about freedom into which the relation existing between the three variables enters as an undefined term. Weale, op. cit., p.51

some as legitimate (within the terms of some, as yet unspecified, moral theory) while dismissing others. Demands for freedom become specific and contextualised. Rather than simply asserting - dogmatically - that freedom is valuable, MacCallum's formula brings into focus the various points at which value enters discussions of particular freedoms. It has, of course, been argued that freedom is valuable in and of itself or, in other words, that freedom is intrinsically valuable. For MacCallum, however, statements concerning liberty will always belie values other than liberty as ultimate objectives³⁶. Freedom, or liberty, is always of something to do something, so that what is clearly seen to be valuable is what it is that one wants (or perhaps needs) to do. MacCallum's is not the only criticism possible against the claim that freedom is intrinsically valuable. A further criticism (and one that also applies to the presumption of freedom) is that not all freedoms are thought to be valuable, or at least not equally so³⁷. If freedom as such were valuable, then there would be no criteria for deciding amongst a range of possible freedoms, and this seems counter-intuitive for there are freedoms which are relatively uninteresting (the freedom to scratch our heads; the freedom to hop on one leg) and freedoms which are generally held to be of some import (freedom of speech; freedom of thought). In the context of practical politics, if freedom is intrinsically valuable, then social policy aimed at enhancing or maximising freedom would be stymied without some means of ordering or selecting amongst a vast range of possible and actual freedoms. In order to do this, one would have to

36. 'Only when we determine what the men in question are free from, and what they are free to do or become, will we be in a position to estimate the value for human happiness and fulfilment of being free from that (whatever it is), to do the other thing (whatever it is).' - MacCallum, op. cit., p.189

37. Joseph Raz, The Morality of Freedom, (Oxford: Clarendon Press, 1986), pp.12-14

specify reasons as to why some freedoms are more valuable than others. But those reasons could not be that freedom is intrinsically valuable, for even if one held that freedom **x** was more valuable than freedom **y** one would have to say something more than that **x** had more intrinsic worth than **y**; for example, that **x** led to the development of character. Such a move would suggest that **x** was valuable, not intrinsically, but for some other good. But if freedom is valuable because instrumental in attaining some other good, goal or end, then the task of the theorist is to find some means of evaluating the worth of those goods, goals or ends for which freedom is valuable, in order to establish their legitimacy as objects of social concern. And if the value of freedom derives from the value of the goals upon which those freedoms are contingent, then freedom cannot be appealed to as an independent principle against which those goals may be evaluated. To do so would be circular. In this respect, liberty fares no better than need as an organising principle for social policy.

The problem that concerns us consists in finding some principle that would enable the social theorist to decide which from amongst a range of actual or potential objectives ought to be given priority. We have seen that neither the alleviation of need nor the securing of liberty are adequate for this purpose. The difficulty in both cases is that each of these objectives is valuable only in terms of some further account of the good, not yet specified. What is required is a principle that will yield up a clear ordering amongst a set of objectives. In the following section, we again concentrate on a representative sample of two such principles. The first proposal is that developed by John Rawls, in his influential work A Theory of Justice (1972); the second proposal is that

made by Raymond Plant, Harry Lessing, and Peter Taylor-Gooby in their work Political Philosophy and Social Welfare (1980). Both theories give the concept of autonomy a central place.

I.iv: Grounding Social Policy: Justice as Fairness and Autonomy

(a) Rawls and the Free, Rational Person

Rawls, in his A Theory of Justice, proposes what amounts to a neo-Kantian system where principles of justice which will define the fundamental terms of association between 'free and rational persons' are to be chosen from behind a 'veil of ignorance' which, it is claimed, is an 'initial position of equality'³⁸.

... we are to imagine that those who engage in social cooperation choose together, in one joint act, the principles which are to assign basic rights and duties and to determine the division of social benefits.³⁹

If this can be done, then we would have a set of, if not value-free principles, then at least a set of value-neutral principles with which to guide our policy making. But the conditional in the preceding sentence is important. The problem is whether or not it makes sense to talk of persons as 'free and rational' in the sense Rawls requires. Persons may well be rational (although this would have to be explored in greater detail) but are they free? Rawls presents his theory as a response to classical utilitarianism, which he criticises as not taking seriously enough the differences between persons⁴⁰. This is a criticism

38. Rawls, op. cit., p.11

39. Rawls, ibid.

40. Rawls, op. cit., p.27

that has been levelled at Rawls' theory itself⁴¹. Rawls seems to suggest that we are capable of shedding our cherished beliefs, our tastes, our opinions and so on in order to get ourselves into the original position from which we would choose our fundamental principles. Even assuming this were possible, we might also want to criticise the character of the 'free and rational' person in the following way. A principle of justice, it would seem, assumes that those over whom it ranges, or those persons for whom it is acceptable, are capable of understanding and experiencing injustice. Why, otherwise, would we want to set the thing up in the first place? But if persons are to understand (however rudimentary such an understanding may be) such an experience, then there must be states of affairs they can recognise as either just or unjust. In order to overcome this difficulty, it is necessary to attribute characteristics to the 'free and rational' being, and this is what Rawls does. Rawls' 'Aristotelian Principle' asserts that:

... other things equal, human beings enjoy the exercise of their realized capacities (their innate or trained abilities), and this enjoyment increases the more the capacity is realized, or the greater its complexity.⁴²

Rawls also specifies a list of 'primary goods' which all persons may be said to value. These include rights, liberties, opportunities, powers, income, wealth and 'self-respect and a sure confidence in the sense of one's own worth'⁴³. But such characteristics are not logically deducible from the concept of a 'free and rational' person. There is no reason,

41. Plant et al, op. cit., pp.128-129. A similar criticism has been made by Onora O'Neill, who notes that Rawls, in order to set up the 'original position', assumes a society of mutually independent agents. O'Neill argues that, in reality, the desires and attitudes typical of human agents are interlocked and cannot meaningfully be forced asunder. "Constructivism in Ethics" in Proceedings of the Aristotelian Society, LXXXIX, (1989/9), p.5

42. Rawls, op. cit., p.426. Cf. Brian Barry, The Liberal Theory of Justice, (Oxford: Clarendon Press, 1973), pp.27-29

43. Rawls, op. cit., p.92; p.396

for example, why a free and rational person should not opt for the life of a hermit.

Rawls also suggests that the free and rational agents who are to construct the principles of justice:

... know the general facts about human society. They understand political affairs and the principles of economic theory; they know the basis of social organization and the laws of human psychology. Indeed the parties are presumed to know whatever general facts affect the choice of the principles of justice.⁴⁴

This is a tall order, and, what is more, many of these 'general facts' are themselves disputed⁴⁵. What, for example, is the basis of social organisation? Is it self-interest? Is it security? The upholding of property rights? Rawls' theory has been developed as a court of final appeal as to the principles that should be adopted when disputes arise. Yet it seems to require the resolution of many of those disputes as a precondition for its implementation. There is, of course, much that is valuable and interesting in Rawls' theory, but, in its account of the kind of person required to operate the system, it (paradoxically, given the previous discussion of accounts of human nature in policy formulation) seems incapable of bridging the gap between abstraction and practical life. Rawls' difficulty here is attributable to his account of what it is to be a person. It might, of course, be the case that a modified account would fare better but it is not our task to test this claim. Instead we turn to an alternative attempt to ground social policy - that developed by Plant et al in Political Philosophy and Social Welfare.

44. Rawls, op. cit., p.137

45. Plant et al, op. cit., p.128

(b) The Autonomous Person and Social Policy

The problem identified thus far is that there appears to be no ground upon which to build a theory of social policy that does not leave itself open to counter-claims from those who happen to occupy a different ground. If it is accepted, however, that whatever one's grounding principles are, they are also moral principles, then - potentially, at least - a way out of the impasse is opened. For although there may be rival views as to which set of moral principles is to be the guiding principle in the generation of social policy, it is nevertheless the case that those arguing for a particular account of social policy will have some moral principles. In other words, contenders in the debate will be moral agents. If it can be shown that there are certain characteristics that all moral agents share, then it might be possible to ground a theory of social policy on these shared characteristics. Plant et al suggest that there is one such characteristic which is presupposed by any moral system, and this is autonomy. From this premise they argue that it is possible to derive a set of basic needs which ought, therefore, to provide a minimum but logically compelling rubric within which to set social policy. There is one other commitment that moral systems produce which gives rise to a parallel, but equally compelling need, and it is that of physical survival. The justification for the inclusion of survival as a basic need is that if there are to be moral systems at all, then there must exist moral agents⁴⁶. This can be readily accepted, provided that we read it as a statement about the conditions necessary for morality to exist (i.e. that there be autonomous agents, as opposed to robots) and not as an instruction to create those conditions (i.e. have babies). What seems less easy to

46. Plant et al, op. cit., p.38

agree to is the subsequent claim that:

... if human beings have moral duties at all, they have a need to survive, which in its turn implies a duty to help each other to survive and to preserve life.⁴⁷

Leaving aside the apparent circularity of this claim (duties are derived from needs which are derived from duties) the clear implication here is that 'needs create obligations'⁴⁸ and it is fairly easy to refute this claim. I may need a fishing rod in order to spend a weekend on the riverbank, but the fact that I need this item does not imply that someone therefore has an obligation, or a duty, to supply me with it. The claim that human beings have a need to survive because they have moral duties is also suspect, not least because some people have, in the past, considered it part of their moral duty to give up their lives for their country, friends, family or whatever.

It is also similarly difficult to support the corresponding, implied claim that because a person has moral duties (whatever they might be) then others have a corresponding duty to help that person to survive. I may consider it one of my moral duties to help preserve the life of others, but this duty will be derived from the moral code or system of ethics to which I subscribe. Suppose (to employ R.M. Hare's famed example) that I were a Nazi, committed to the destruction of Jews, homosexuals and several other clearly defined non-Aryans. I would be in the peculiar position, according to Plant et al, of both having a duty (since they are moral agents) to preserve all these people's lives and a duty (as a good Nazi) to ensure that they forfeit their lives. What

47. Plant et al, ibid.

48. This quotation, attributed to Simone Weil, is used as a legend to the chapter "Needs, Welfare and Social Policy", Plant et al, op. cit., p.19

these authors appear to want to argue for is a principle of respect for others which encapsulates more than just a negative duty to leave people alone and not to interfere with them. The question is whether or not they need to construct a separate category of needs, beyond the bounds of autonomy, in order to achieve this?

Plant et al themselves suggest that certain basic needs can be derived from the fact that there exist autonomous agents, although these needs are expressed as negative freedoms. Autonomy requires freedom from exercises of arbitrary power, freedom from ignorance, and freedom from ill-health⁴⁹. It is, of course, possible to express these positively as rights - a right to political freedom (however this is to be defined); to education; and to health-care. The list is, of course, open to negotiation. Nevertheless, deriving these needs from the principle of autonomy does seem to provide a ground upon which to construct social policy, if it is accepted that the difficulties of establishing a ground for social policy in the first place arose as a result of the existence of moral agents, with rival conceptions of morality. This is not unproblematic, and in the following section we consider some of the difficulties such a position entails.

49. Plant et al, op. cit., pp.46-51

I.v: Moral Autonomy and Personal Autonomy

It should, of course, be noted immediately that Rawls himself has an account of autonomy at the heart of his theory of justice. What we need to do then is to consider how, if at all, Rawls' account of autonomy differs from that offered by Plant et al. The most important difference is that Rawls ties his account of autonomy to the 'free and rational' person criticised above. For Rawls, to act autonomously is to act:

... from principles that we would consent to as free and equal rational beings.⁵⁰

Furthermore, these principles are to be willed from behind the 'veil of ignorance', and in this sense, claims Rawls, they are or will be objective⁵¹. It would be impossible to do justice to the sophistication of Rawls' system here, but one important criticism may be reiterated concerning the rational status of the principles adopted by the autonomous agent. If it is the case that there is a set of principles which may be willed from behind a 'veil of ignorance' by a free and rational agent, then it would seem to be the case that all free and rational agents must also will those principles in a similar situation. This is the universalising element in Rawls' theory. The Kantian equivalent of these principles would then be what Kant himself referred to as 'the Moral Law'. The problem for both Rawls and Kant, is that neither the principles chosen from behind the 'veil of ignorance', nor the Moral Law, allow for differences (of taste, value, preferences, or ideals) amongst moral agents⁵². For Kant, the more individuals - in their striving to become rational, moral agents - approach the Moral

50. Rawls, op. cit., p.516

51. Rawls, ibid.

52. See J.L. Mackie, Ethics: Inventing Right and Wrong, (Harmondsworth: Penguin Books, 1977) pp.83-102 for a general criticism of universalisation. For this point in particular see especially pp.92-97

Law, the more they look like every other moral agent. Differences between individuals (in a moral sense) only occur to the extent that those individuals either misinterpret, or fail to understand correctly, the dictates of the Moral Law⁵³. Similarly with Rawls. To the extent that individuals divest themselves of their own particular 'attachments and interests', to the extent, that is, to which we choose a set of principles 'unencumbered by the singularities of the circumstances in which we find ourselves'⁵⁴, then to that extent will we arrive at the principles of a just society. But to that extent also do we cease to be individuals. Even Rawls' account of autonomy fails to take the differences between individuals seriously. Does that offered by Plant; Lesser; and Taylor-Gooby fare any better?

In a sense, it does. All that is required - initially, at least - by these authors is that individuals be capable of formulating moral principles, and Kantian morality is but one amongst a vast range of moral positions one may take up. On these grounds, the difficulty of restricting the social obligation to supply resources to human animals, and not non-human animals mentioned above might be overcome. Animals are (or at least are thought to be, although this remains to be proven) incapable of moral thinking. That individuals are to be capable of moral thought must be taken to mean that individuals be potentially capable of moral thought. Certain classes of humanity are usually taken to be presently incapable of moral thought, but potentially capable -

53. A fundamental tenet of Kant's philosophy as such (and so of his moral philosophy) is that human beings are fallible. If they were not, they would be Gods. Since they are not Gods but human beings, they will always individuate themselves in failing correctly to discern the moral law (or alternatively in approximating closer to it than some but not others).

54. Rawls, ibid.

children, for example, and the mentally ill for whom there is some hope of treatment or cure. There are, however, some unfortunate people who seem to be permanently incapable of moral thought - the mentally deranged or retarded - and these might present a problem to the general thesis proposed by Plant et al. The argument that the mentally deranged are sufficiently like sane people for them to be treated in a like fashion begs the obvious question; in what way are they sufficiently like sane people? The reply that they look like us is clearly inadequate (so do display mannequins in shop windows), as is the Benthamic reply that they feel pain like us (since this invokes the equally Benthamic response - so do animals), and in any case neither would be admissible within the scope of the general theory advanced. The only admissible response within the terms of this theory is that they are (potentially) capable of formulating and acting upon moral principles, or, since Plant et al define autonomy as 'the freedom to act morally'⁵⁵, that they are (potentially) capable of acting autonomously⁵⁶. Either way, there seems to be a difficulty here concerning the scope of the theory.

Even if, sweeping aside the difficulty pointed out above, we accept the

55. Plant et al, op. cit., p.46

56. The problem of mental disorder is one of degree. Paternalistic intervention is usually justified on the grounds that the mentally deranged or retarded are incapable of looking after themselves. But few mentally disordered people are completely incapable of this. Daniel Wikler has identified a potential difficulty here, for it seems that benevolent intervention by society rests on an assumption that those of higher or 'superior' intelligence are in a better position to know what is in the interests of those less intelligent than themselves. Wikler feels this to be an unfair assumption, leading to an unnecessary disregard for the autonomy (such as it is) of mentally disordered people. The unfairness is brought out if one generalises the assumption in the following way: that those of superior intelligence always know what is in the interests of those less intelligent than themselves. Wikler, "Paternalism and the Mildly Retarded" in Philosophy and Public Affairs, (1979), Vol.8, pp.380-381

argument that human beings are capable of morality, it remains unclear as to why it is this feature of the human condition that creates an obligation on the part of humanity in general and society in particular and not some other feature. Why morality and not the fact that human beings feel pain? The argument that all human beings are potentially moral agents seems less secure than the argument that all human beings feel pain. Even the mentally deranged, if they are incapable of morality, are nevertheless capable of experiencing pain. It remains unclear as to why the capacity for autonomy - defined thus far as the freedom to act morally - is thought to be of greater value than the capacity for liberty, or for happiness.

Another problem concerns the connection between the claim that human beings have a capacity for autonomy, a capacity for acting morally, and the conditions in which that capacity might flourish. It requires a special interpretation of what it is to be a moral agent to enable one to conclude that a range of conditions is necessary (or not) for one successfully to be morally autonomous. A Kantian view of what it is to be moral, for example, makes no reference to a set of external conditions which may or may not facilitate the development of morality in an agent. Conformity to a set of rational principles requires no particular social arrangements, unless one can build into the theory an argument which suggests that one's ability either to discover those rational principles in the first place, or to enact them once discovered depends on a set of material circumstances. One way in which this might be done is to suggest that we are all - more or less potentially - moral agents, but that certain aspects of our environment prevent us from developing to the fullest possible extent the morality of which we are

ideally capable. This is, crudely at any rate, the position taken by T.H. Green for whom the positive benefit of supplying resources to individuals is that it enables them to become moral, or at least more moral than they already are. It is not that the having of resources of itself creates morality, but rather that it removes obstacles to the development of the self-determining (i.e. autonomous) individual⁵⁷.

One possibility as to why there are these difficulties at the heart of Plant et al's argument, is that they conflate two separate and distinct notions of 'autonomy'. As we have already seen, for these authors autonomy is 'the capacity to act morally', but as Raz has pointed out it is both possible and desirable to make a distinction between moral autonomy and personal autonomy. Moral autonomy is associated with the Kantian idea of self-enacted moral principles that accord with a rational Moral Law. It is itself a theory about the nature of morality. Personal autonomy, on the other hand, is 'a particular ideal of individual well-being' which is 'no more than one specific moral ideal which, if valid, is one element in a moral doctrine'⁵⁸. For Kant, the autonomous person is the person who acts in accordance with the dictates of his or her rational will. But this is not the only account of autonomy that may be given. It is possible to distinguish, for example, between rationality and authorship, such that an autonomous person is held to be one whose actions emanate from the self, from his or her will, but not necessarily in accordance with a rational principle.

57. Individuals, for Green, are intrinsically social beings: '... the human spirit can only realise itself, or fulfil its idea, in persons, and... it can only do so through society, since society is the condition of the development of a personality', Prolegomena to Ethics, Fourth Edition, (Oxford: Clarendon Press, 1899), pp.226-227

58. Raz, op. cit., p.370 (n.2)

Autonomous actions may emanate from non-rational, or even irrational emotions such as love or loyalty⁵⁹. It may be rational, or just, or in accordance with utility to save the life of Bishop Fenelon rather than his valet - who happens to be my brother - but in choosing to save the valet I could not reasonably be accused of acting heteronomously.

A further advantage of keeping moral autonomy distinct from personal autonomy is that it goes some way towards clearing up the problem, articulated above concerning the conditions for autonomy. If it is difficult to relate moral autonomy to a requirement for the resources which social policies are designed to provide (and, after all, the most ascetic of monks can be as moral as the average non-monadic person, if not more so), then the same cannot be said of personal autonomy. This is because personal autonomy is not merely about judgements, or rational principles, but about enactment. It has a substantial element to it that moral autonomy lacks, and it is this substantial element that makes it, and not moral autonomy, an object of social policy. In order to substantiate this claim, it will be useful at this point to turn to a discussion of one aspect of personal autonomy frequently encountered in the literature - the concept of a plan of life.

59. The distinction between rationality and authorship is discussed by Richard Lindley in his Autonomy, (London: MacMillan, 1986), p.21. One should not forget that, for Kant at any rate, rational principles are, by their very nature, universalisable.

I.vi: Personal Autonomy and Plans of Life

We have so far noticed a distinction between moral autonomy and personal autonomy. While our interest is with the latter, it is nevertheless worth noticing that it is possible to distinguish between two kinds of personal autonomy - occurrent (personal) autonomy, or autonomy of the moment, and dispositional (personal) autonomy, which takes into account a person's life as a whole⁶⁰. It is with the latter that plans of life are usually associated. This distinction in part attempts to come to terms with a problem encountered in Mill's On Liberty. This is the difficulty, for Mill, of reconciling his account of the limits of interference in the private sphere (that is, of self-regarding actions) with his argument concerning the selling of oneself into slavery, thereby surrendering all future liberty. Young suggests that the decision to perform this act is an example of occurrent autonomy, and occurrent autonomy, since it is of less importance than dispositional autonomy, may be over-ridden in favour of the latter⁶¹. Whether or not we agree here turns on what we understand by a plan of life. All the same, if what Young says is substantially correct then the importance of an understanding of the notion of a plan of life to a discussion of autonomy is clear. But for our purposes, there is another reason for considering what is entailed by the notion of a plan of life. We are, after all, attempting to explore the nature of the connection, if any, between social policy and autonomy. If, as has been suggested, the notion of a plan of life is important in understanding autonomy, we shall want to know what the relationship is between plans of life and

60. Robert Young, Personal Autonomy: Beyond Negative and Positive Liberty, (London: Croom Helm, 1986), p.5

61. Young, op. cit., pp.72-75. Young argues that dispositional autonomy will usually override occurrent autonomy, but not always.

social policy. In order to do this, it will be important, in the following discussion, to emphasise the substantive side of personal autonomy. Raz, for example, makes a distinction between autonomy as capacity and autonomy as achievement⁶². It does not follow from this distinction (and Raz would not claim that it did) that to be autonomous one must always achieve one's objectives. But of itself, the mere having of the capacity for autonomy is fairly uninteresting. It would be difficult to maintain that a person was autonomous if he or she consistently failed to enact the projects he or she autonomously decided upon. For the same reason, personal autonomy is not merely about opportunities to exercise one's capacities⁶³. To be autonomous one must, at least some of the time, exercise one's capacity. One must, at least some of the time, realise one's objectives⁶⁴. If autonomy is really to be an object of social policy it must have some content, it must be substantial, and not merely formal. Although this claim is not directly linked to plans of life, it may be indirectly linked in that persons who claim to have a plan of life (or a set of interconnected plans), assuming that they are sincere in their claim, will want to implement that plan (or set of plans). Insofar as a plan of life is a substantive thing, it too may require space in which to flourish, and may require resources to enable its owner to implement it. In short, it may be of legitimate interest to someone charged with formulating social policies. If this is so, and if the connection between (dispositional) autonomy and plans of life is well-founded, then the contention that autonomy

62. Raz, op. cit., pp.203-207

63. Young, op. cit., p.49

64. Autonomy, says Charles Taylor, is an 'exercise-concept'. Taylor, "What's Wrong With Negative Liberty?" in Alan Ryan (Ed.), The Idea of Freedom: Essays in Honour of Isaiah Berlin, (Oxford: OUP, 1979), p.177

might justifiably be an object of social policy may itself be reinforced.

David Miller, in Social Justice, offers us an account of a plan of life which incorporates the social roles one occupies (work, leisure, family, and so on), the social ideals one subscribes to (whether one seeks the maintenance of the status quo, or its disruption, for example), the projects one has (such as cataloguing all the butterflies in the British Isles) and the personal relationships one enters into⁶⁵. Plans of life (we shall use this as a generic term for all those things referred to by Miller) are taken to be those things that give meaning to a person's life. The notion of a plan, or plans, of life has been taken up by a number of political and social theorists, and it is worth considering why this is so.

One suggestion for the interest accorded to the notion is the potential inherent in it for clarifying and uniting a number of important areas of social policy. As we have seen, one of the central problems for social

65. David Miller, Social Justice, (Oxford: Clarendon Press, 1976), pp.133-134. See also John Rawls, A Theory of Justice, pp.407-416. A plan of life, for Rawls, is something that is chosen with a person's 'full deliberative rationality' (p.408). Miller's account seems to allow for the inclusion in a person's plan of life of eventualities not deliberately chosen, but not repudiated either. One does not choose one's parents, but one may nevertheless, and without rational deliberation, accept and foster the relationship one has with them. Albert Weale's account emphasises the subjectivity of plans of life, or projects, in Political Theory and Social Policy, pp.24-29, while Bill Jordan stresses the limiting nature of commitments made by autonomous agents - to friends, relatives, clubs, societies, religions, political parties and organisations of many kinds, in Rethinking Welfare, pp.17-18. On this last point see also Gerald Dworkin, The Theory and Practice of Autonomy, (Cambridge: Cambridge University Press, 1988), pp.23-24

policy is that of scope. What are, and what ought to be, the legitimate concerns of social policy? Attempts to be more specific about the scope of social policy have focussed on the concept of need. But need, as we have seen, is itself too broad a concept to perform the function ascribed to it in this case. The problem lies in deciding which, amongst a vast array of needs, are to count as an appropriate object of social policy. One solution is to invoke a biological standard - those needs that are to count as a justifiable object of social policy are those directly connected with keeping an individual alive. In a modern social context, however, subsistence is rarely used as a criterion for the distribution of benefits. This is because in a modern, industrialised society there arise needs which have a social dimension. The difficulty is well-illustrated with regard to the concept of poverty. Since poverty is a relative concept, it will differ from place to place, and also from time to time. If this is the case, then needs arising as a result of being poverty-stricken will also differ from place to place, and time to time⁶⁶. The needs one has in the context of a modern industrialised

66. Although needs defined in this way are relative, they are nevertheless objective insofar as they make reference to an externally-set standard (i.e. external to those who are said to have the need). A. J. Culyer has discussed this with reference to the National Health Service, where a patient's needs are, he claims, defined and delineated by professionally trained experts in the field of medicine. Apart from the authoritarian implications of Culyer's claim, it also seems to be counter-intuitive, for it follows that, where there is no third party to evaluate whether or not a need exists in a given situation, then no need can be said to exist. A person dying of thirst in the desert (the example is Culyer's own) 'may want [water] as much as it is possible to want anything, but he does not, by our definition, need it'. A. J. Culyer, Need and the National Health Service, (London: Martin Robertson, 1976), p.16. For a criticism of Culyer, see Peggy Foster, Access to Welfare, (London: Macmillan, 1983), p.20. What Culyer may be said to be doing is articulating the moral nature of welfare distribution, assuming that morality is a social phenomenon,

(Cont'd over...)

society will differ from those in a primitive tribal society because needs, social needs, are tied to the notion of a standard of living.

Miller suggests that the concept of a social need can be understood in terms of harm. The claim here is that, for the purposes of social policy at any rate, a person needs something if that person will suffer harm without it⁶⁷. Miller has two reservations about this claim. Firstly, it cannot be sustained without making reference to the aims and aspirations of the person who is thought to be suffering, since what is harmful to one person may not be harmful to another⁶⁸. The second concerns what Miller describes as 'strong theories of human nature' which attempt to set up a standard for the human condition. Harm is then defined in terms of a deviance from this standard. But this may be unwarranted since the person may have willingly chosen to deviate, may have decided to 'drop out' or become a monk, or an ascetic. In either case, reference must be made to the aims and aspirations of the person who is said to be either in need, or harmed. Invoking the notion of a plan of life allows Miller simultaneously to define both harm and need:

(Cont'd from previous page)

concerned with relationships and conduct between individuals, or groups. If need is a moral concept (and not, for instance, merely a biological concept) then it cannot exist outside of a social context. We must suppose that this is the point of Culyer setting his example of the thirsty man in a desert - a non-social environment where one is unlikely to come across a need-legitimising third party.

67. Miller, op. cit., pp.130-132

68. Miller uses the example of the philosopher Brentano who became blind later on in life. An 'objective' assessment of Brentano's predicament might conclude that, since blindness is a form of harm, the philosopher suffered as a result. Brentano's own account of his situation disagrees with this assessment. Blindness, he argued, freed him from the distractions imposed by sight, enabling him to become a more effective philosopher (p.131).

Harm, for any given individual, is whatever interferes directly or indirectly with the activities essential to his plan of life and correspondingly, his needs must be understood to comprise whatever is necessary to allow these activities to be carried out⁶⁹.

This may be a good way to define both harm and need, but it remains unsatisfactory as a means of defining or delineating the scope of social policy. The problem lies in the subjective nature of the notion of a plan of life. If, as Miller suggests, a person's plan of life incorporates social roles, ideals, projects, and relationships, then clearly these will differ from person to person. Given this, the problem for the formulator of social policy then becomes one of a practical nature: if social policy is to cater for needs then in order for social policy to be effective it is necessary to know what the needs of individuals are. In other words it is necessary to know what are the plans and projects individuals subscribe to. Were the policy-maker merely to guess, he may create more harm than he alleviates⁷⁰. There are other problems for policy-makers who are thinking of adopting Miller's criterion of need. One person's plans and projects may conflict with another person's - in cases where positional goods are at stake, for example. It is not unrealistic to suggest, since a person may have several overlapping plans or projects in operation at any one time, that there may be some internal conflict on occasion. Plans of life need not be specific or detailed, and they may be liable to revision in the light of new information and changing circumstances. The sheer variety of plans and projects amongst individuals makes them unlikely candidates as a basis for social policy unless some means of ordering them in terms of

69. Miller, op. cit., p.134

70. This, of course, is the problem faced by utilitarians, or at least those utilitarians who subscribe to Bentham's hedonistic account of human psychology, as set out in his The Principles and Morals of Legislation, (New York: Prometheus Books, 1988), pp.1-7

priority can be discovered.

One way in which these problems can be circumvented is to move, as it were, to a second-order level of inquiry, and look, not at the plans and projects that people have, but at the conditions that can be said to be necessary in order effectively to formulate those plans and projects in the first place. This is the move made by Plant et al⁷¹ and explains why, as we have seen, they stress the importance of autonomy (though now understood as personal autonomy), for the important thing about a person's plans and projects is that they are that person's own and no-one else's. This is not to say that a person merely identifies with the set of plans or projects he or she has (since a person may identify with plans, projects, values, opinions, motives and so on, while having been duped or manipulated into having them), but rather that the person has autonomously chosen them, or has adapted someone else's⁷². The task of social policy thus becomes the securing, for all persons, 'of the material conditions for autonomy'⁷³. As already pointed out, for Plant et al, these conditions will include freedom from arbitrary exercises of power, freedom from ill-health, and freedom from ignorance. There are two points to be made here concerning this list of, what are described by the authors as 'basic needs'.

First, they require some substantiation. This might seem obvious, but the task is nevertheless far from straightforward. The first condition,

71. Plant et al, op. cit., pp.37-51. See also Raymond Plant's "The Very Idea of a Welfare State" in P. Bean; J. Ferris; D. Whynes (Eds.), In Defence of Welfare, (London: Tavistock, 1985)

72. For accounts of the problem of identification see Young, op. cit., pp.42-46; Dworkin, op. cit., pp.15-17

73. Weale, op. cit., p.198

for example, might be said to be the whole problem of liberalism, in as much as that branch or mode of political philosophy is concerned to establish the correct and justifiable extent of interference with personal liberty, by both government and by fellow citizens. The second condition is tied to the notion of health, and this in itself is problematic for two reasons. The first of these concerns the concept of health itself and how we are to understand it. The second concerns the relationship that can be said to exist between autonomy and health. Both of these issues will be explored in greater detail in subsequent chapters⁷⁴. The third condition - freedom from ignorance - translates both as a demand for information, and for education. Mill himself recognised the importance of education, both for those who wish to participate in a modern, representative democracy⁷⁵, and for the task of self-improvement⁷⁶. Equally important, however, is information. The connection with autonomy requires explication at this point. This is because it might seem that there is a sense in which, at least the quality of information is irrelevant to autonomy. No matter how poor the quality of information available to a person, the decision that a person makes on the basis of that information might be said, nevertheless, to be autonomous. After all, as critics of certain robust accounts of the free-market point out, individuals rarely, if ever, have perfect information. This absence of perfect information, it might be said, need not and, as a matter of fact, does not prevent individuals from making autonomous decisions.

74. Chapter Three, **sections v and vi**

75. J. S. Mill, "Considerations on Representative Government" in Utilitarianism; On Liberty; and Representative Government, Edited by H. B. Acton, (London: J. M. Dent & Sons Ltd., 1972), p.280

76. Mill, "On Liberty" in op. cit., pp.160-163

But this ignores the manipulation of information by various parties. If autonomy is self-determination, then I cannot be said to be autonomous if I make a decision based on deliberately misleading information. I am not autonomous if I am being manipulated by some person or institution who is feeding me either false or even partial information without my being aware of it. If ensuring the conditions for autonomy is to be the task of social policy, some attention must be paid to this problem. In fact, of course, in the United Kingdom (and elsewhere) attention has been paid to at least one important aspect of this problem. Advertisers are required at least not to lie in advertisements, because to make false claims for a product is to deceive the customer. Outright lying, therefore, is not permissible. But the corresponding problem of misleading, through presenting only partial truths or partial information, is not regulated in the same way, if at all. This form of deception can be undertaken in a number of ways. It can be done by simply failing to tell someone of the pernicious effects of a product or practice. This is the activity now widely known as 'being economical with the truth'. The argument is that, although a person is not being told the whole story, or is not being given the full picture in a particular situation, then that person is not being lied to and hence no harm is being perpetrated. Such arguments trade on the moral dilemma of whether or not omitting to do something (or, in this instance, omitting to tell someone something) is tantamount to causing them harm. This has come to be known as 'bad-samaritanism'⁷⁷. There are other ways in which information may be made either palatable (if it is unpleasant) or

77. E. Weinryb, "Omissions and Responsibility" in Philosophical Quarterly, (1980), Vol.30, pp.1-18; E. Mack, "Bad Samaritanism and the Causation of Harm" in Philosophy and Public Affairs, (1980), Vol.9, pp.230-259; J. Harris, "Bad Samaritans Cause Harm" in Philosophical Quarterly, (1982), Vol.32, pp.60-69

confusing and even impenetrable (if it cannot be made palatable) without actually lying about a product or practice. Information may also be made difficult to obtain, if it is likely to cause embarrassment to an interested party.

The second point to make about Plant et al's list of 'basic needs' - the conditions for autonomy - is that they may be interconnected. Freedom from ignorance, for example, may itself be a condition of freedom from ill-health. If, for example, individuals are to become more responsible for their health (as the **Prevention and Health** campaign - discussed in Chapter Five (below) proposed), then one important resource is information. It has been said that the key to preventive health-care is education⁷⁸ Yet health education - information pertaining to preventive activity - may itself be subject to the practices outlined in the previous paragraph. If health education is to be successful or, to put it another way, if the individual is effectively to assume responsibility for his or her own health, then the quality of information must be such that it enables that individual to pursue the aims effectively. Health then, as a condition of autonomy, may be dependent (to some extent at least) on the quality, and even quantity of information - another condition of autonomy - that is made available.

78. This is a long-established contention. It was proposed, for example, in the opening decades of this century (and in the context of venereal disease prevention), by Charles Osborne in his pamphlet **Ignorance, The Great Enemy**, (London: National Council for the Combatting of Venereal Diseases Pamphlet NC6, 1916), p.22

I. Conclusion

In **section i** of this chapter we examined some of the assumptions that may be said to underpin both political theory and social policy. We suggested that the account one gives of society, and of the individuals that make up that society, will influence the way one constructs both political theory and social policy. But given that there is a variety of often incompatible accounts of society and of human nature, the problem arises of arbitrating amongst them. In **section ii** we examined the idea of social policy itself, rejecting positivistic definitions as inadequate because incapable of accounting for both difference (between, say, one society and another) and change (i.e. the development of policy within a society). An alternative way of characterising social policy was proposed, and this involved focussing on the objectives at which social policies are said to aim. In **section iii** we examined two of the more important objectives - the alleviation of need, and the securing of liberty - but found each of these inadequate as an organising principle for social policy. The reason for this was that each required further justification because neither the existence of needs nor the desire for liberty could secure the attention of the social theorist without the employment of some separate and additional argument, the task of which would be to establish a priority of certain needs and liberties over others. In **section iv** we considered two candidates for this kind of argument - Rawls' neo-Kantian account and Plant; Lesser; Taylor-Gooby's account of autonomy. Rawls' account was rejected as too formal, a legacy of its overt Kantian heritage. Plant et al's account was accepted with reservations as accommodating the differences between persons (that individuals will differ as to their own account of the Good) while pointing to an apparently universal characteristic of the human

condition - the capacity for moral autonomy. In **section v** we considered some difficulties with this account, especially its focus on moral autonomy, since this invokes once more the shade of Kant. The formal character of Kant's rational moral philosophy makes it difficult to derive any practical policy conclusions, although Plant et al claim to derive three broadly welfarist conclusions. In order to overcome this problem we proposed to replace the formalistic notion of moral autonomy with the more substantive notion of personal autonomy. In the final part of this chapter, **section vi**, we related personal autonomy to plans of life, in order to establish the substantive nature of this account of personal autonomy.

In the next chapter, we explore further some of the issues raised in Chapter One. In **section i** we examine in greater detail the neutrality of the concept of autonomy. In **sections ii** and **iii** we examine the relationship between moral autonomy and personal autonomy in order to establish the priority of the latter over the former. In the final three sections, we attempt to counter the individualist associations that autonomy-based theories are often said to entail by relating personal autonomy to a social context through the notion of 'social forms'.

Chapter II: Autonomy and Neutrality

II. Introduction

In the previous section, we made some moves towards establishing the credentials of autonomy as an organizing principle for social policy. The desirability of finding a unifying principle arises, as we saw, as a result of the allegedly evaluative nature of debate concerning the scope of social policy. Since the objectives at which social policies aim are (or so the argument goes) essentially contested, then there will always be dispute about the nature and scope of social policy. If this is a problem (and not everybody will agree that it is), then the advantage of a unifying principle will be to secure agreement as to those objectives indicated by the principle, allowing those charged with the task of policy-making to get down to the practical problem of how best to achieve those objectives. In the last chapter, we examined both the alleviation of need and the securing of liberty in this context, but found them to be inadequate. It seems that if the organizing principle is to arbitrate amongst a variety of evaluative concepts, then it must itself be value-neutral, otherwise there will be no reason to look to it rather than some other value-laden or value-dependent concept as a guide to social policy. If it is not itself value-neutral, then it must either be ranked above other value-laden or value-dependent concepts in some lexical way, or it must be intrinsically valuable. The first part of this chapter considers the 'neutrality' of autonomy. Taking personal autonomy as the focal point, the discussion in **section i** considers the problem of neutrality from the perspective of a particular theory or tradition of thought. This is intended to pave the way for a consideration (in Chapter Three) of personal autonomy within what may broadly be described as the 'liberal-democratic' tradition. In **sections ii** and **iii** the relationship between personal and moral autonomy is

examined in some detail, in order to establish the priority of the former over the latter. In the final three sections of this chapter, we examine the criticism, sometimes made of autonomy-centred theories, that they are inevitably individualist. This will allow us to explore a difficulty that arises from Raz's flawed account of the relationship between personal autonomy and social forms, while at the same time enabling us to demonstrate the social nature of our account of autonomy. The importance of first, establishing that there is such a relationship, and second, of understanding that relationship, lies in the practical implications of our account of personal autonomy, if this particular account of personal autonomy is to be successfully and usefully employed in the formation of social policy. Some of these implications - with regard to an aspect of health policy - will be discussed in the final two chapters of the thesis.

II.i: Autonomy and Neutrality

Before we commence our discussion, a difficulty inherent in this project needs to be indicated. Autonomy, if it is value-neutral, may not be the only value-neutral concept available to those seeking a unified ground for social policy. We have, for example, considered a possible alternative - Rawls' 'Justice as Fairness'. Although our conclusion there was that Rawls' attempt fails, there may still be other candidates for a neutral grounding of social policy¹. But if there are other candidates then, potentially at least, a theoretical difficulty arises concerning the choice of unifying principle. After all, if there is a variety of such principles, has not the difficulty encountered at the level of social policy and its objectives simply been reproduced at a higher, or 'second-order' level?² If this is so, then the search for a principle of choice at this higher level seems desirable and necessary, but there is no reason to think that the second-level problem will not reproduce itself at the third, fourth, or even fortieth level. An infinite regress seems to be the likely outcome of this approach. It is unclear why one neutral principle should be preferred to another. To see

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1. Of the most important of the neutralist moral principles, Kant's has been effectively subsumed under our criticisms of Rawls in chapter one, while utilitarianism will be addressed below. Another neutralist moral theory - that developed by R. M. Hare in three books, The Language of Morals, (Oxford: Clarendon Press, 1952), Freedom and Reason, (Oxford: Oxford University Press, 1963), and Moral Thinking: Its Levels, Method and Point, (Oxford: Clarendon Press, 1981) - will not be dealt with here. The important characteristics of moral decision-making - prescriptivity and universality - are essentially (and with many qualifications) those of Kant. We may, for the purposes of this thesis at least, take it that the criticisms that may be levelled at Rawls and Kant might also, very generally, be levelled at Hare. Nozick's neutralism will be discussed shortly.
 2. Rawls' broad aims might command our attention, but what is missing is an argument suggesting why his (and not some other) formulation of the veil of ignorance ought to be employed. This point is raised by Joseph Raz, The Morality of Freedom, (Oxford: Clarendon Press, 1986), p.125

how this difficulty impinges on our argument we will look at two of the more influential works of political theory published in (fairly) recent years - Rawls' A Theory of Justice and Nozick's Anarchy, State, and Utopia.

(a) Rawls and Neutrality

We shall deal with Rawls very briefly, since we have discussed his theory elsewhere. It will be remembered that there are two fundamental principles which Rawls suggests will rationally be chosen from behind the veil of ignorance. The first of these - the principle of equal liberty - need not concern us. The second - the difference principle - acknowledges that individuals will differ as to the details of their plans of life but stipulates a list of 'primary social goods' which, it is suggested, all individuals will require in order to pursue their diverse goals. These include 'rights and liberties, opportunities and powers, income and wealth'³. Rawls' supposed neutrality has been criticised on the grounds that these primary goods are themselves far from neutral with respect to the conceptions of the good pursued by individuals, militating against, for example, non-individualistic conceptions while ruling others out altogether⁴. It has also been pointed out that the original position itself presupposes, not a neutral theory of the good, but a recognisably liberal, individualistic conception:

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3. John Rawls, A Theory of Justice, (Oxford: Clarendon Press, 1972), p.92. Rawls later adds a sense of one's own worth to the list - see p.440
 4. Thomas Nagel, "Rawls on Justice" in N. Daniels (Ed.), Reading Rawls, (Oxford: OUP, 1975), pp.8-10

... according to which the best that can be wished for someone is the unimpeded pursuit of his own path, provided it does not interfere with the rights of others.⁵

The criticism here is of a second order variety. It is not suggested that the neutralist elements of Rawls' theory - the original position; the liberty principle; etc. - are in fact agent-relative. Clearly, these elements are neutral amongst persons (at least insofar as they accord with the account Rawls gives of what it is to be a person). The criticism is rather that these neutralist principles are embedded in a theory supported itself by a set of assumptions which are themselves far from neutral.

(b) Nozick and Neutrality

A similar difficulty seems to infect Robert Nozick's 'neutrality' in his Anarchy, State, and Utopia. For Nozick, if a state is to claim the allegiance of its citizens, it must be 'scrupulously' neutral between them⁶. It is not the business of the state to promote an ideal of the good. Nor is it the business of the state to enable individuals to do this. These remarks concerning the scope of state action are premised upon the claim that:

... there is no social entity... There are only individual people, different individual people, with their own individual lives.⁷

This is itself a recognisably individualist position, and as we saw in chapter one it is not the only position that may be adopted with regard

5. Nagel, ibid. It has also been suggested that Rawls' difference principle, and the specific benefits to which it is applied, can be used to support a materialist ideology which asserts the centrality of consumption in human life. John Watt, "John Rawls and Human Welfare" in Radical Philosophy, (Summer, 1988), No.49, pp.3-9

6. Robert Nozick, Anarchy, State, and Utopia, (Oxford: Basil Blackwell, 1974), p.33

7. Nozick, op. cit., pp.32-33

to the nature of society.

Nozick is sensitive to the accusation that his account of the reach of the state is non-neutral. After all, Nozick's minimal state is constructed (maybe 'dismantled' would be better) so as to support a particular account of property rights, a particular distribution of property, a particular legal framework, and so on. Nozick suggests that the accusation of non-neutrality here arises because in enforcing (neutral) prohibitions, the state may sometimes differentially benefit its citizens. Differential consequences are not intended by the state, and so long as a given prohibition is 'independently justifiable' - that is, so long as the prohibition is justified by independent reasons and not by the fact that it results in differential benefits - then, according to Nozick, there is 'no reason to condemn it as non-neutral'⁸. Whether or not the independent reasons justifying the enforcement of a prohibition must themselves be neutral is unclear. Nozick does not tell us, for example, whether or not a neutral prohibition can be justified by independent non-neutral reasons. Nozick's example is the enforcement of a prohibition against rape. This prohibition differentially benefits the citizenry (it safeguards women and not men because the legal system does not recognise that a man can be raped, though he can be assaulted) but is justified by a set of independent reasons - that people (male or female) have a right to control their own bodies; that they have a right to choose their own sexual partners; and that they have a right to be secure against physical force⁹. These independent reasons are indeed neutral amongst persons (they apply to all people), but the choice of

8. Nozick, op. cit., pp.272-273

9. Nozick, ibid.

independent reasons cannot be said to be neutral. Why these and not another set of rights? Why rights at all? The point is, of course, that the rights cited in the example look suspiciously like the kind of rights that come with Nozick's libertarian territory, and not everyone will share Nozick's libertarian presuppositions.

Even if this difficulty in Nozick's account of neutrality were to be overcome, it is still possible to question the assumption that the state, in pursuing neutrality, must always be blind to the consequences of its actions. A utilitarian, for example, might want to abandon Nozick's procedural neutrality for a consequentialist version, which required the state to treat people differentially in order to achieve a neutral outcome amongst its citizens. This might be the case with state-administered health care where the object is to achieve a neutral outcome (health for all), but where some people (diabetics, for example) require a level of resources not needed by others in order to achieve this goal. Nozick's difficulty may stem from a presumption (again perhaps part of his libertarian baggage) that inaction on the part of the state is on the whole more likely to be neutral than action. As we saw in the previous chapter, this is morally suspect. Remaining aloof while two ill-matched people fight, and knowing that one could successfully intervene to stop the stronger beating the daylights out of the weaker, is not to remain neutral. It is tacitly to acquiesce in an already imbalanced contest. Nozick's argument, of course, is about retaining one's neutrality when acting (or, more specifically, enforcing prohibitions) rather than omitting to act, and this is achieved by acting for some independent reason, rather than some differential outcome. But consider how odd it would be to claim that in the Gulf War

the British and American armies, because they were fighting for an independent reason (the right of small nations to determine their own destiny, for example) were therefore neutral in the conflict¹⁰.

We have marshalled a number of criticisms of neutrality here. We must now consider how these criticisms relate to our previous discussion (in Chapter One) of autonomy. The problem can be stated in the form of a question: is autonomy a neutral principle such that it would serve as an adequate organizing principle for social policy? Before we answer this question, we need to recall a distinction, articulated in the previous chapter, between two kinds of autonomy - moral and personal. We shall consider moral autonomy first before turning to personal autonomy.

(c) Moral Autonomy and Neutrality

In the previous chapter, we noticed that Raz distinguished moral autonomy from personal autonomy on the grounds that the former was a particular type of moral doctrine, usually associated with the (Kantian) notion of acting in accordance with a set of rational (and therefore universalizable) principles - the Moral Law, or similar. It looks as though, on this reading at least, moral autonomy is by its nature a neutral principle, exemplified by the Kantian categorical imperative to treat people, regardless of any personal characteristics they may have, as ends in themselves, and never as a means to some further end. Of itself, of course, the Kantian injunction here has a recognisably

10. This is to adapt Raz's example concerning the sale of arms to one of two combatants, for the independent reason of making a profit. Raz's example leads him to conclude that Nozick's state is not a neutral one, and that he does not, in fact, have a principle of neutrality. Raz, op. cit., p.116

liberal ring to it¹¹. If this is so, then we might reasonably level the kind of criticism at the notion of moral autonomy that we levelled at both Rawls and Nozick, i.e. that moral autonomy itself is contentious and far from neutral. The problem is that a moral theory may advocate neutrality, but the moral theory might not itself be neutral amongst moral principles generally. This is partly because the criteria of neutrality are themselves constructed within a particular moral or political context. This is clearly the case with Nozick, but it is no less the case with Rawls or Kant. Both the original position and the Kantian injunction are criteria of neutrality, and while either might command widespread acceptance, they are nevertheless contentious principles from the outset, liable to second-order criticism. If this is so, it begins to make the task of finding a neutral principle upon which to secure agreement over the objectives of social policy look fundamentally hopeless. The question now is whether or not personal autonomy might serve as a candidate for a neutral principle.

(d) Personal Autonomy and Neutrality

As we saw in chapter one, Raz suggests that personal autonomy is itself 'no more than one specific moral ideal which, if valid, is one element in a moral doctrine'¹². If this is so, then there seems no reason to suppose that it is the kind of principle that we (and Plant et al) are looking for. Personal autonomy (at least on Raz's account) is supervenient upon a moral doctrine, and moral doctrines may be agent-relative or neutralist. There is no reason to believe that personal

11. T.H. Green utilised the Kantian injunction in his Prolegomena to Ethics. For an example of his use of the injunction see section 183. Rawls also employs the device, or at least an interpretation of it, in A Theory of Justice, pp.179-183.

12. Raz, op. cit., p.370, (n.2)

autonomy is incompatible with agent-relative moral principles. In fact, it might actually be better-suited to an agent-relative account of morality, since these, generally speaking, attempt to take some account of the differences between persons¹³. However, the fact that personal autonomy might theoretically be compatible with both agent-relative and neutralist moral theories suggests that, at the second order level, it could prove to be the kind of principle we are looking for. In order to conclude that personal autonomy were a neutral principle of the type we require, we would have to show that it was, in fact, a feature of all moral doctrines. This is conceivably what Plant et al mean to suggest when they claim that autonomy (that is, personal autonomy) is the capacity to act morally. There are two ways that we might possibly proceed at this point, in order to establish whether or not personal autonomy is a neutralist principle.

First, we might explore in some detail what it is to be a moral agent. The intention here would be to consider whether or not personal autonomy is relevant to morality as such. If, for example, it could be shown that personal autonomy was, in fact, a feature of all moral activity then Plant et al's project might receive a considerable boost (though it still might not do all the work they require of it). We shall explore the relevance of personal autonomy to morality through a discussion of Raz's account of the relationship in his The Morality of Freedom.

13. This is the position taken by Bernard Williams in his critique of utilitarianism. See J. Smart; B. Williams, Utilitarianism: For and Against, (Cambridge: Cambridge University Press, 1973). See also his "Persons, Character and Morality" in Moral Luck, (Cambridge: Cambridge University Press, 1981).

The second avenue of exploration would involve us in recognising the limitations of neutralist principles, thereby allowing us to work within a set of acknowledged constraints. The constraints we have in mind here are those imposed by history. This sounds grandiose, but what is intended is a recognition that the importance accorded to autonomy derives in part (and a substantial part at that) from a particular dominant tradition of political practice. In this case, and broadly stated, liberal democracy. This strategy will be pursued in Chapter Three (**section i**) through an account of the liberal democratic tradition.

II.ii: Autonomy and Morality

In the following section we explore the connection between autonomy and morality. The central purpose is to consider the status of personal autonomy as a neutral concept upon which to ground social policy. However, a subsidiary purpose will be to expand on, and clarify, the distinction noticed in the previous chapter between personal and moral autonomy. This task will be pursued largely through a critique of the account of personal autonomy developed in Joseph Raz's The Morality of Freedom. It will be shown that Raz's account of personal autonomy is restrictive, and that the connection between it and what Raz terms 'social forms' is problematic.

Before we turn to a discussion of Raz, let us restate an ambiguity noticed earlier in the account of autonomy given by Plant et al. It will be remembered that autonomy is defined by these authors as the freedom to act morally. This is ambiguous because it is not yet apparent how we are to understand the term 'morally'. It may mean either of two things.

Firstly, the term 'moral' may be set against the term 'immoral', where a person acts as a moral agent, but in consciously breaking a moral code. To act morally, in this sense, is to act in accordance with a moral code of some sort. Secondly, the term 'moral' may be set against the term 'amoral', where a person either breaks or acts in accordance with a moral code of some sort but does not do so consciously or willingly. In this case, the person who breaks a moral code (or acts in accordance with it, albeit unwittingly) is not morally culpable (or praiseworthy), since the person is not, strictly speaking, a moral agent. If the moral/immoral distinction is intended by the authors, then they seem to be saying that the purpose of society's distributing benefits is to make people moral, or good, rather than immoral, or wicked. If the moral/amoral distinction is intended, then the purpose of society supplying benefits to its citizens is to enable them to become moral agents as such, and this for better or worse, since they may autonomously then choose wickedness over good, or vice versa.

It would seem that it is the latter distinction that is intended by the authors for two reasons. Firstly, the former distinction seems too strong. It may be desirable that the members of a society act morally rather than immorally, but social policy cannot guarantee this or, at least, the kind of social policy envisaged by Plant et al cannot. Survival might reasonably be thought to be a condition of morality, since without moral agents there can be no morality. But freedom from ignorance - one of Plant et al's basic conditions for living the autonomous life - need not necessarily lead to moral, as opposed to immoral, behaviour. It is true that the ancient Greeks, and especially Aristotle, generally associated morality with knowledge so that to be

ignorant of one's duties was to be immoral¹⁴. But to be ignorant of one's duties would now be more readily associated with amorality than immorality. To be immoral, in contemporary terms, is to know what one's duties are but to shirk them all the same. Knowledge may lead to immorality just as easily as it might lead to morality - as when someone uses knowledge in order to blackmail a third party. Health too, can be a condition of morality in the second sense. This is most obviously the case when it is one's mental health that is of concern. For example, an accusation of guilt may be waived if it can be established that the accused acted in a condition of 'diminished responsibility'. To regain one's mental health is not therefore to become moral in the first sense, since, having emerged from a bout of mental illness, one might then go on to perform immoral acts, if one so chose.

The second reason for opting for the morality/amorality distinction can be illustrated if we consider the second strand to Plant et al's argument for society's guaranteeing a certain level of resources to each individual. This is the connection with plans of life. The authors

14. This is R.M. Hare's formulation of the logic of moral statements in his Moral Thinking, (Oxford: Oxford University Press, 1981), p.24. Hare also considers rationality a characteristic of moral thinking, and in this he perhaps betrays his Kantian allegiances, problems with which we have already dealt (in Chapter One). Hare's is not the only account of morality one can give, of course. Even butterfly-collecting could be made part of a moral enterprise if some Aristotelian notion of virtue were to be adopted, such that there could be virtuous (i.e. morally praiseworthy) butterfly-collectors - those who thoroughly and diligently indexed and cross-referenced their collections, say - and vicious butterfly-collectors - those whose collections were none of these things. Something of this notion is to be found in Alasdair MacIntyre's account of the goods (virtues) internal to practices - see his After Virtue, (London: Duckworth, 1981), esp. Chapters 14 and 15 passim. This account of morality has its problems. We would not, for example, think a serial killer a Good Man because he went about his chosen hobby conscientiously and with zeal.

accept that there are many different kinds of plans and projects - goods - pursued by the members of any society. It would therefore be impossible for society to cater directly for the minutiae of the various plans and projects individual members might conceive of. But what society can do is to ensure that, as far as possible, the plans and projects that its members make are autonomously chosen, and it is to this end - ensuring that individual members of society are in a position to choose autonomously - that social policy is to be geared. But if we are to understand Plant et al as equating autonomy with acting morally or rightly, as opposed to immorally or wrongly, then we must conclude that the plans and projects with which individuals give their lives meaning are by their nature moral pursuits. If the freedom to act morally is the freedom to act rightly, then the plans and projects pursued by each individual must be moral goods. The conclusion would be, on this reading, that whatever a person chose autonomously to do was right.

But this is a curiously rigid understanding of morality, for it is difficult to see how a person could ever act immorally. What is missing from this account is any sense that morality has a social content. We shall explore this shortly when we turn to Raz's account of personal autonomy. But reading Plant et al in this way also ignores the possibility that some plans and projects that a person adopts might have little or no moral content anyway. To set oneself the task of cataloguing the butterflies of the British Isles might be interesting and useful in itself, but it is unclear that it is a moral pursuit. If, as some have argued, it is a logically necessary component of moral thinking that it incorporate both universalizable and prescriptive

elements, then some plans and projects are clearly not moral pursuits¹⁴. A butterfly collector would presumably be loathe to prescribe universal butterfly collecting since to do so would be self-defeating - there would not be enough butterflies to go around. Some plans and projects might even depend on positional goods, the value of which might derive from the fact that obtaining them excludes others from obtaining them too.

A more sophisticated account of the connection between morality and autonomy can be found in Joseph Raz's The Morality of Freedom, and it is to this account that we now turn. What interests us especially with regard to Raz's account of personal autonomy is its connection with morality through the idea of a 'social form'. However, before we turn to this aspect of the theory, we shall set out some difficulties inherent in Raz's account of the distinction between personal and moral autonomy.

II.iii: Joseph Raz - The Morality of Autonomy

Raz, in his important work The Morality of Freedom, is concerned (in part at least) to clarify the connection between autonomy and morality. According to Raz, amongst the conditions necessary for the exercise of autonomy is a requirement that a person have an 'adequate range of options' from which to choose¹⁵. What counts as an adequate option is, Raz admits, difficult to specify, but certain criteria are thought to be important. There should, for example, be options of 'long term pervasive consequences as well as short term options of little consequence' in order to allow a person to exercise control over all aspects of his (or her) life, and there should be a variety of options too, rather than an

15. Raz, op. cit., pp.372-378

abundance of uniform or similar options¹⁶. But whatever these options are, they must share at least one characteristic - they must be 'morally acceptable'¹⁷. This is because personal autonomy, according to Raz, 'is valuable only if it is exercised in pursuit of the good'¹⁸. If 'good' here means morally significant, then Raz's claim, on his own admission, is false. This is because the 'adequacy of options' criterion ranges over profound, but also over trivial choices 'such as when to wash or when to comb our hair'¹⁹. It is true that, if personal autonomy is but one ideal amongst a number within a moral doctrine, the moral doctrine might conceivably transform washing or combing one's hair from a trivial matter into one of some moral force. Washing my hands in the morning might be a fairly trivial action to me, but to a moslem personal cleanliness is an act of devotion and far from trivial. All the same, this is not what Raz is claiming. He does not say that the 'adequacy of options' criterion ranges over trivial choices which are no longer trivial because they have been given moral significance by the overarching moral theory in which personal autonomy is embedded. On the contrary, and despite Raz's claim that autonomy is valuable only if used in pursuit of the good, it seems that trivial options, options of little or no moral worth, are to be included in the options to be made available to autonomous agents²⁰.

16. ibid., pp.374-375

17. ibid., p.378

18. ibid., p.379

19. ibid., p.374

20. In the section on "Personal Well-Being" (op. cit., pp.288-320) Raz introduces the notion of 'comprehensive goals'. These are based on social forms and are, as such, morally significant. Social forms will be discussed in some detail below, but for now we need only note that Raz's distinction here may be said to echo Lindley's distinction between dispositional and occurrent autonomy. We may assume that, for Raz as for Lindley, trivial, or less comprehensive, goals may plausibly be sacrificed in favour of more comprehensive goals.

The general claim that autonomy is valuable only if it is exercised in pursuit of the good admits of two possible criticisms.

The first concerns the status of any moral system in a person's life. If what counts as good (or bad) is derived from a system of morality, then it seems to follow that, even if one were brainwashed into acceptance of that particular moral system, one may still live the Good Life simply by obeying the tenets of that system. The range of choices may be wide within the terms of that system, thus ensuring that one has (on Raz's terms) considerable personal autonomy. But surely something has gone wrong here? We would be happier with it if we could be sure that the moral system itself were (autonomously) chosen by the agent. This, after all, is why we do not necessarily think of nuns and monks as dupes or robots for we assume that their mode of life has been (autonomously) chosen by them. We would also want to ask what kind of a decision one makes when choosing amongst rival moral systems. If personal autonomy is one element within a moral system, and moral autonomy is itself a moral system, what kind of a decision is one making when one accepts (or rejects) Kantian ethics, utilitarianism, Christianity, Islam, or New Age mysticism? If such a decision is autonomous then it follows that the value of personal autonomy for Raz rests itself on a presupposition of autonomy - the ability to freely choose a moral doctrine for oneself. If Raz's two-fold distinction exhausts the notion of autonomy, then it seems that a choice between moral doctrines could not be made autonomously. This is surely wrong. The conclusion must be that Raz's account of the distinction between moral and personal autonomy is either too restrictive or it is circular.

If Raz's account of personal autonomy is too restrictive, then a second difficulty also arises. It involves the notion of blame, or culpability and may be approached through a question Raz himself poses. Raz says:

No one would deny that autonomy should be used for the good. The question is, has autonomy any value qua autonomy when it is abused? Is the autonomous wrongdoer a morally better person than the non-autonomous wrongdoer?²¹

Raz is surely correct to answer, as he does, in the negative. The autonomous wrongdoer is clearly more culpable, from the moral point of view, than the person who is driven by hunger, or neuroses, or some other form of compulsion. But what Raz misses is that autonomy is itself then a prerequisite, a condition of morality. (This is the second of the senses discussed earlier, with regard to Plant et al) It is by no means clear that a person, acting under some compulsion or other, could properly be said to be acting morally or immorally at all²². A person who, while hypnotised, commits an act of murder at the suggestion of the hypnotist is not morally culpable, not even as an accessory to the murder. This is because he or she is not autonomous. On the other hand, a person who coldly plans and executes a murder is culpable precisely because he or she is autonomous. The value of autonomy here is not that it is used for the pursuit of some good, but that it enables us to

21. Raz, ibid., p.380

22. Admittedly the nature of compulsion is disputed. There are compulsions and there are compulsions. The case of someone hypnotized differs from the person who steals because he is hungry and cannot afford to buy food. The person who is hypnotized has no idea that the act they are performing is wrong. On the other hand, the person who steals because he is hungry and cannot afford food may know that his act is 'wrong' (in the sense that it goes against the prevailing morality where stealing is thought to be wrong) but may perform it all the same. He may even think it 'right' (either because he disagrees with the prevailing morality or because he thinks that other considerations - a right to life say - ought to override the injunction not to steal). Unlike the hypnotized murderer, the thief is an autonomous agent but acting under the compulsion of hunger.

discriminate between two kinds of act: on the one hand, blameworthy or praiseworthy (or simply moral acts) and on the other, non-moral acts. Autonomy as such may be necessary to living the Good Life, but it is also necessary for living the Bad Life, if one so chooses. The autonomous wrongdoer is not 'morally better' than the non-autonomous wrongdoer because the non-autonomous wrongdoer is not a moral agent.

This might seem overly strict. After all, children sometimes perform 'wicked' acts, incurring the displeasure and condemnation of their parents and (sometimes) society, and children are not usually thought of as autonomous agents (or at least not fully autonomous). We do then, it might be concluded, hold people responsible for acts they have performed regardless of whether or not they have been performed autonomously. But to punish a child for a 'wicked' act is not to punish them for wickedness as such. It is rather to instill in them a sense of what wickedness is and of the kind of behaviour that is required of them in society²³.

It is the capacity for autonomy that enables us also to make a distinction between two kinds of responsibility. In the examples given above, both the hypnotised 'murderer' and the murderer proper are undeniably responsible for the death of their respective victims. Both undeniably caused their victims to die, in a straightforward physical sense. In the case of the hypnotised 'murderer', the relationship he had

23. There are acts which are wrong (they offend against the prevailing morality) but do not result in the perpetrator being labelled 'immoral'. Killing someone is usually wrong, but if a murder is performed accidentally or through ignorance of the prevailing moral codes, then the actor is not necessarily acting immorally. Ignorance does not make the act right but it does not make the ignorant immoral either.

with his victim was of the same kind as the person who dies in a flood or avalanche. There is no blame (in a moral sense) to be attached to merely physical causes of death. In this sense, it is not the hypnotised killer who is responsible for the murder; it is the hypnotist who implanted the suggestion. The hypnotist - in a paradigmatic anti-Kantian sense - is using the hypnotised person as a means to his own end, as a mere instrument. The same is not true of the murderer proper who not only physically causes the death of the victim, but also intends that death to happen.

Personal autonomy, as we shall understand it, will be that capacity that allows us to choose the kind of life we are to lead, including which moral doctrine we wish to adopt. It is therefore not itself a moral doctrine but a characteristic of human nature, a condition of living a certain kind of life, whatever that life may be. We have, in other words, turned Raz's account on its head. It is personal autonomy that is prior to moral autonomy, and not personal autonomy that is contingent upon a moral doctrine.

We have suggested that autonomy is not a component part of a moral doctrine, but is itself a precondition of moral activity. One problem with this account is its tendency to make individuals look like self-contained units, free from external pressure, and devoid of social context. In order to counter this criticism, we will turn now to the second aspect of Raz's theory that interests us - the connection he attempts to make between morality and what he calls 'social forms'.

II.iv: Autonomy and Social Forms

In The Morality of Freedom Raz attempts to overcome the morality versus prudence (or altruism versus self-interest) dichotomy by focussing on the idea of well-being. Briefly, the well-being of a person, according to Raz, consists in 'the successful pursuit of valuable goals'. Baldly stated, this is quite compatible with any individualist account of the good, and also with any account that trades on a notion of self-interest. But although he is self-avowedly developing a liberal political theory, Raz is concerned to rescue liberalism from the accusations its critics often make that it ignores the essentially social nature of human beings. To this end, Raz develops his account of well-being through the notion of a social form. We shall quote in full the passage from which the previous quotation was excerpted before offering some tentative criticisms:

Given that the well-being of the agent is in the successful pursuit of valuable goals, and that value depends on social forms, it is of the essence of value that it contributes to the constitution of the agent's personal well-being just as much as it defines moral objectives. The source of value is one for the individual and the community. It is one and the same from the individual and from the moral point of view. Individuals define the contours of their own lives by drawing on the communal pool of values. These will, in well-ordered societies, contribute indiscriminately both to their self-interest and to other aspects of their well-being. They also define the field of moral values. There is but one source for morality and personal well-being.²⁴

Raz's claim is that well-being is a broader, more accomodating concept than self-interest, and is not, unlike that concept, to be contrasted with morality. But what gives it its special edge in Raz's theory is its connection with social forms. Let us now examine this connection.

The striking thing about Raz's account of the relationship between

24. Raz, op. cit., pp.318-319

individuals and their community is its similarity to Wittgenstein's account of the nature of meaningful behaviour, as set out in his Philosophical Investigations. Wittgenstein's project, of course, is not Raz's, but let us explore the similarities. Wittgenstein's concern is with knowledge, but his focus is on the importance, to our understanding of the world, of language. Language is the key to knowledge, but it is also the key to understanding society. This is because language is rule-governed, and rules, for Wittgenstein, are essentially social phenomena²⁵). Meaning, and hence understanding, is possible insofar as words and concepts are used according to rules. This linguistic argument is generalised in the Philosophical Investigations to society. For human behaviour to be meaningful it must be carried out in accordance with socially-generated rules. For human behaviour to be intelligible then it must be rule-governed. There are two consequences of this account of meaningful behaviour.

The first is that, if it is true, it demonstrates the essentially social character of human interaction. An individual's life will only be meaningful in a rule-governed (i.e. a social, or potentially social) environment. Meaningful existence therefore is social existence. It depends, that is, on the existence of what Wittgenstein calls forms of life²⁶. These are given, in that they precede any individual's existence. This is not to say that individuals are powerless to affect these rules, or that they are entirely shaped by them - there need not

25. This forms part of Wittgenstein's argument against the possibility of a private language - since any language must, if it is to be intelligible to its user, be rule-governed, and since rules, in principle, may be discovered and learned by other people, then it follows that no language cannot be learned by other people.

26. Ludwig Wittgenstein, Philosophical Investigations, (Oxford: Blackwell, 1953), II, xi., p.226

be, to employ (in a modified fashion) Raz's disclaimer about his own account, 'an inevitable identity between [social] and personal concerns'²⁷. Wittgenstein does not specify in any precise way what is, or is not, to count as a form of life. Given our initial account of his concerns in the Investigations we might conclude that a form of life is a linguistic community, but this notion is unclear. It is unclear because there is not only a multiplicity of languages, but also of dialects of languages. There are also linguistic sub-cultures which develop particular linguistic usages as a means both of identifying those who are 'in' and marking off those who are to be excluded. Pop culture provides the best examples of this phenomenon, but other examples abound - 'Gay' slang, for instance.

On the other hand, a form of life might be a rule-governed enterprise. When one is at work, one implicitly obeys a set of rules concerning what one does and how one does it. The same goes for a variety of other activities (in fact, all intelligible activities) such as worshipping at one's church, buying one's weekly provisions, walking one's dog, and so on²⁸. If, for Wittgenstein, there is no identity between social and individual concerns it is because the social is not monolithic.

Individuality is guaranteed, at the very least, by the sheer variety of forms of life one may attach oneself to. One person may be a member of the Roman Catholic church, a local councillor, a keen tennis-player and a good husband - all rule-governed activities; while another may also be

27. Raz, op. cit., p.319

28. One need not be aware that one's behaviour is so governed. The sociologist may want to elucidate the rules that a person is implicitly obeying, but one need not (always) do this for oneself. It is nevertheless always possible in principle to do this. See Peter Winch's account of this in his The Idea of a Social Science, (London: Routledge & Kegan Paul, 1958), pp.51-57

a member of the Roman Catholic church but also a shop-assistant, an opera buff, and unmarried; and so on. Indeed, in a sense one could say that there are as many forms of life (read, say, as a network of attachments rather than a linguistic community) as there are people. This captures the sense in which, for Raz, an individual, while drawing on the 'communal pool of values', can nevertheless create something unique and valuable for themselves - their own life²⁹.

Raz is himself unclear about what we are to understand by a social form. He is clear (and here he echoes Wittgenstein) that behaviour is given significance through social forms, but although he initially refers to social forms as 'forms of behaviour which are in fact widely practised in... society'³⁰, he does not want to focus narrowly on human behaviour. For this reason he suggests that social forms 'consist of shared beliefs, folklore, high culture, collectively shared metaphors and imagination, and so on'³¹. He is equally clear that the importance of social forms relates to the comprehensive goals a person finds valuable. Social forms underpin the goals that a person values even if those forms, despite being widely practised, are not 'socially approved'³². We shall return to this point shortly.

The second consequence to be drawn from the Wittgensteinian account of meaningful behaviour is that any criterion of intelligibility also

29. See Raz on how combining 'elements of two [or more] existing socially recognizable forms' may lead one significantly beyond those forms to create something entirely new, op. cit., p.309. See also p.387

30. Raz, op. cit., p.308

31. Raz, op. cit., p.311. Although he does suggest that social forms are 'forms of behaviour which are in fact widely practised in... society', p.308

32. ibid., p.310

provides us, simultaneously, with a criterion of unintelligibility, that is, it provides us with a criterion of correctness but also for error. As Winch has noted, 'the notion of following a rule is logically inseparable from making a mistake'³³. If Wittgenstein is right about the importance of rule-following to intelligibility, then it would seem we have a criterion by which to evaluate the actions of individuals. More importantly, since rules are in principle discoverable, we have a criterion by which we might evaluate our own actions. In this resides the possibility of morality. As Winch again puts it: 'I understand what it is to act honestly just so far as and no further than I understand what it is not to act honestly'³⁴. One can only be moral if one understands the alternatives open to one in a given situation. One cannot properly be called moral if, through ignorance of alternatives (whether intrinsic to the agent or externally imposed by someone else), one is not aware of alternatives to what one is doing. Here we see a connection with Raz's account of autonomy, and his stress on the importance of adequate choices. A person who has no option but to perform an act, no matter how good the consequences might be of performing it, is not morally praiseworthy³⁵.

The social specificity of Raz's account of morality rests on two

33. Winch, op. cit., p.32

34. Winch, op. cit., p.65

35. A consequentialist might disagree, of course. For utilitarians, an act is moral if it produces an excess of pleasure over pain, and wrong if the opposite. The intentions of the agent are irrelevant - see John Stuart Mill's statement regarding this in "Utilitarianism" in H.B. Acton (Ed.), Utilitarianism, On Liberty, and Considerations on Representative Government, p.17. It is equally irrelevant, of course, as to how autonomous an agent is when performing a 'moral' act. Acts performed by hypnotised agents may be judged on the basis of their consequences, in the same way as those performed by agents free from hypnosis.

different claims. Firstly, morality is itself drawn from the 'communal pool of value', so that even if it is reinterpreted extensively (as with some breakaway religious sects) it nevertheless owes a debt, as it were, to society. There is, it may be said, a dialectical relationship at work. The second aspect of morality rests on the criteria of success, which may underpin the notion of well-being. For Raz, it is a person's well-being that depends on his or her ability to 'make sense' of their own lives³⁶. Now it is true that this may well be a personal criterion (as in 'doing one's best' or 'giving it one's best shot') and this might bring some satisfaction to an individual, knowing that they have tried their best even though they may have failed to achieve the goal. But sometimes success is more than merely a personal criterion. A person who requires to pass an exam to either obtain a job or earn promotion will hardly be fully satisfied with knowing that they did their best. To do one's best is not enough to succeed. One must also, in order to succeed, meet the accepted, public criteria of success - a certain number of marks in the exam.

Raz's account of the relationship between morality and social forms is interesting, but ultimately problematic. The difficulty for the account lies in the vagueness of the notion of a social form. We turn now to a consideration of the difficulties inherent in Raz's account of the concept. What we shall be particularly concerned to explore is the tension between public standards of success and private standards.

36. Raz, op. cit., p.319

II.v: Personal Goods, Moral Goods and Social Forms

According to Raz, social forms consist of 'shared beliefs, folklore, high culture, collectively shared metaphors and imagination, and so on'. As forms of behaviour, these are 'widely practised' in society. The 'comprehensive goals' that a person has must be based on a social form. On the face of it, Raz appears to be offering us a stipulative definition of the term 'comprehensive goal'. If a person claims to have a comprehensive goal not based on a social form Raz would presumably be committed to the claim that they are simply wrong. There can be no such thing as a comprehensive goal that is not based on a social form. Raz, however, offers a qualification:

The view to be defended... is that a person can have a comprehensive goal only if it is based on existing social forms... which are in fact widely practised in his society.³⁷

The distinction we are offered is between goals based on widely practised social forms, and goals which are not. The former are comprehensive goals, while the latter, presumably, are not. The question we need to address here is whether or not this distinction holds up. The crucial idea expressed in Raz's qualified formulation is that of a widely practised social form and it is in pursuing this point that the distinction can be seen to break down.

Raz might mean by 'widely practised' that a lot of people, perhaps a majority, within a society engage in a given social form. The term 'majority' itself can be understood in a variety of ways, ranging from a simple majority (about 51% of a population) to just short of unanimity (up to 99% of a population). This is a numerical interpretation of 'widely practised', but Raz may intend here a spatial metaphor. A widely

37. Raz, op. cit., p.308

practised social form in this sense might be one practised throughout a society rather than localised within a specific community, even if this practise were to be undertaken by a relatively small number of people. Playing football on Sunday mornings is, in this sense, widely practised even though, taking the population as a whole, very few people actually play the game. One of the few hard examples discussed by Raz is the institution of marriage suggesting the spatial metaphor (since there are substantial numbers of the population of Britain - those yet to marry, those who have no desire to marry, those who are divorced or widowed, those ineligible for marriage such as children - who do not practise this particular social form). All the same, the spatial metaphor is itself problematic. How small a number can the practice get away with and still be a social form? Raz mentions the medical profession, yet very few people, on the whole, are doctors.

Some social forms, it is suggested, are institutionalised. They require an institutional setting not merely in order that a practice be engaged in, but because some social forms are impossible outside of an institutional setting. It is impossible to pursue a legal or medical career, claims Raz, in a society that is not governed by law or that does not recognize the practice of medicine. We should not take it that a social form can only be something officially recognized, sanctioned by the state, although this conclusion might be drawn from Raz's examples. Indeed, it is explicitly suggested that comprehensive goals may be based on social forms that are not socially approved³⁸. This is at least ambiguous. We may take it in a neutral sense, where society does not explicitly bestow its approval on a practice but does not register its

38. Raz, op. cit., p.310

disapproval either. Such a practice is not approved, in a positive sense at any rate. Alternatively, we may take it, in a negative sense, to mean those practices of which society has explicitly registered its disapproval.

In fact, of course, we must assume that the approval of society is largely irrelevant to the notion of social forms. A member of a criminal fraternity, for example, the mafia, will undoubtedly count the aims and objectives of the organisation to which he belongs as his own. The comprehensive goals that the mafia henchman pursues then have a social element. They do not originate spontaneously from within him, but are drawn from a communal pool of values - the community, in this case being the 'family'. However, society at large may thoroughly disapprove of the activities of that tightly-knit community.

That the community is 'tightly-knit' might seem to disqualify it from inclusion as a social form, since these are supposed to be widely practised. But there are at least three possible responses to this criticism. Firstly, we are not sure exactly what the social form is that we are dealing with. Is it, in this case, the particular mafia 'family', or mafia families generally, or, more generally still, organised crime, or, at its widest, crime as such? Secondly, even if we deny that the mafia family itself is a social form, it would be odd to deny that, because of this, the goals pursued by the individual members were not of the comprehensive variety. Certainly, for the individual members at least, those goals would be thought comprehensive in that they touch every aspect of their lives. The third possible response requires more careful elaboration.

In suggesting that the comprehensive goals pursued by a person must rest on social forms Raz is clearly open to the charge that his thesis is conventionalist. As stated, it looks as though the comprehensive goals open to a person are simply drawn from a collective pool of socially sanctioned conventions. However, Raz does allow that individuals may work transformations upon the basic material that the social milieu presents to them. There may be many deviations from any given social form, but they will be 'deviations on a common theme' so that the general thesis advanced by Raz is compatible with experimentation³⁹. Deviations appear to consist in simply combining elements of two or more existing 'socially recognised forms'. There is nothing objectionable so far. However, we might reasonably wonder how far one has to go before a deviation from a common theme becomes itself something entirely new? Are homosexual marriages really marriages at all? Some would no doubt argue that they are merely an extension of (or deviation from the norm of) the concept of marriage. Others would argue that such marriages are indeed deviations - in the pejorative sense of the word - or even that they were not marriages at all in any sense. Clearly, there is scope for argument as to whether or not a social form is being extended or subverted in such cases - assuming we can agree that it is a social form in the first place. Revolutionary socialism, after all, is a development from within capitalism, but it is not capitalism all the same, and it is not intended to be compatible with capitalism.

There are essentially two fundamental problems then with the account of a social form. The first concerns scope. What is it for something to be 'widely practised' throughout a society? A subsidiary point here is why

39. Raz, op. cit., p.309

it should matter how widely practised an activity is for it to achieve the status of a social form? In a sense, even the most maverick activity within a society takes place in a social setting and therefore might be said to relate to other social forms, even though this might be in a purely negative way. The recluse, for example, relates to the social forms of his or her society by rejecting them. Punk Rock, with its emphasis on anarchy and/or nihilism, was a revolt against the established stalwarts of the rock world. It was therefore closely related to that world, even to the extent of being dependent upon that world for its very existence, but its goal was to undermine it all the same.

The second problem is one of clarity. It is simply unclear - beyond Raz's cluster of examples (marriage, the medical and legal professions, bird-watching societies) - what precisely a social form is. Some (but not all) social forms require an institutional setting, but it is even unclear what an institutional setting might consist of. Two of Raz's social forms are professional bodies. But is bird-watching an institutionalised practice in the same sense? There may be a society of bird-watchers, but it is surely not necessary to belong to that society in order to engage in the activity of bird-watching - and we do not mean here on a casual basis (where any 'sighted person in the vicinity of birds' may be said to be 'bird-watching'). A person, or group of persons, may be thoroughly serious about their bird-watching hobby and still not belong to the society of bird-watchers.

II. Conclusion: Autonomy and Social Policy

Given the above criticisms, the most important and fundamental difficulty for Raz's account of a social form, is in finding an activity not, in some way, related - however tangentially - to such an entity. This, after all, might be Raz's point. It is fairly clear that Raz, in introducing the notion of a social form, intends to make explicit the social nature of much human activity in order to defend liberalism against those of its critics who accuse it of having too abstract an account of the individual. The difficulty for us, however, concerns the implications of this for autonomy as a neutral concept, and it is now time to tie up the various threads of the argument underlying the critical account of social forms.

Our concern, it will be remembered, was to establish whether or not for the purposes of social policy autonomy could be said to be a neutral concept. We proposed to approach this through the subject of morality. Taking it as read that human beings are potentially moral agents, we suggested that, if it could be shown that personal autonomy was a prerequisite of moral (and immoral) behaviour, the claim might fairly well be established as something more than conjecture. The sticking point with our claim is the conflation, by Raz, of two senses of in which an activity could be said to be valuable. When Raz suggests that autonomy 'is valuable only if exercised in pursuit of the good', we may agree wholeheartedly with him⁴⁰. But when he then goes on to state that 'the ideal of autonomy requires only the availability of morally acceptable options' we want to know what the connection is between morally acceptable goods and goods as such. Are they, for example, the

40. Raz, op. cit., p.381

same thing? Recall the example of the butterfly collector discussed above. Here is a pursuit, a goal, a good - and it may well be a comprehensive good at that - which is not self-evidently a moral good. The pursuit may be autonomously chosen, but this consideration does not make it a moral pursuit, although it might significantly increase the value of the pursuit to the butterfly collector.

It might be that goods linked to social forms are morally acceptable, but to claim this falls prey to two difficulties. Firstly, to whom must the pursuit be morally acceptable? The activities of the mafia may not be acceptable to certain sections of society, or to society at large, but they are surely morally acceptable to the mafiosa themselves. If Raz is attempting to defend a Millian position in The Morality of Freedom, he must be aware of the duplicity surrounding the idea of a broad moral consensus informally legislating for the tastes and pursuits of 'eccentric' minorities. On the one hand, minorities are to be protected from the 'despotism of custom' or the tyranny of public opinion, while on the other hand public opinion is to rein back 'anti-social' elements, administering a variety of punishments as it does so. This, of course, is Mill's problem, but until we are sure that nothing of any consequence rests on the attachment of comprehensive goals to 'widely accepted' social forms, then we might justifiably treat Raz's argument here with some caution.

The second difficulty picks up on the problem of specifying which activities (if any) do not, in some sense, attach to a social form, however indirectly. This problem is analogous to the difficulty, which some attribute to Mill, of sustaining a meaningful distinction between

self-regarding and other-regarding actions - it being notoriously difficult to specify acts which are not also other-regarding, however indirectly⁴¹. The effect of this difficulty when it is attributed to Mill is to trivialize the notion of a self-regarding act. The effect of this difficulty for Raz is to trivialise the notion of a social form, for what is not, in some sense, a social form, or connected to, or derived from, a social form? If this criticism is well-founded, then what special work does the notion of a social form now do? And if the goods linked to social forms are morally acceptable, then what is to count as morally unacceptable?

In conclusion then, the comprehensive goals a person values may be those that are linked to social forms, or they may not. The comprehensive goals a person pursues may be morally acceptable to society at large, or they may not be (they may be morally unacceptable to society at large but of great moral import within a sub-culture - as with the activities of terrorists). In a pluralistic society, after all, there will be a plurality of moral positions, as of everything else. Where does this leave the concept of personal autonomy? There are two possible conclusions regarding autonomy as a neutral concept, as a ground for social policy.

First, autonomy does seem to be a condition of moral activity, whether or not that activity results in acts which are morally right or morally

41. We might also distinguish between those self-regarding actions where the consequences fall on the agent performing them, and those that fall on others who have consented to the agent's performing them, as Albert Weale does in his "Invisible Hand or Fatherly Hand? Problems of Paternalism in the New Perspective on Health", in Journal of Health Politics, Policy and Law, (1983), Vol.7(4), Winter, pp.787-788

wrong. Without an assumption of autonomy, morality would make little sense. It is itself a good, or valuable, insofar as we value moral activity which itself rests on an allocation of responsibility. In this sense, to be autonomous is to be responsible. This admittedly is a fairly weak account of autonomy, although it is strong enough to cope with accounts of morality that apparently do not require agents to be autonomous. A morality of duty, such as Hegel posited, requires agents that are not mere unthinking robots. What persons ought to do may be circumscribed by their station in life, but all the same they are required to accept the duties and obligations responsibly. It is, in other words, always - in principle at least - possible for them to shirk the duties of their station. One serious difficulty might come from consequentialist accounts of morality, since these, as we have already remarked, could feasibly cope with a complete absence of autonomy⁴².

Second, autonomy is by its nature a social concept since the choice of goods available to a person, from which that person will construct his or her life, are intrinsically social goods. This, too, is intended to be a fairly weak statement - indicating that where we talk of autonomous persons we are not talking in abstract terms but of social beings, responsible not only for their moral acts but also for shaping their lives in the most general, fundamental of senses. In this respect, we concur with Raz while disagreeing that it is only morally worthwhile options that are valuable. If the choices an individual makes are valuable (for whatever reason) to that individual, they may nevertheless

42. Although it might be possible to develop a consequentialist account that employs autonomy as the good that is to be maximised. For such an account see Lawrence Haworth, Autonomy: An Essay in Philosophical Psychology and Ethics, (New Haven: Yale University Press, 1986), pp.169-182

be considered immoral by society at large (as with homosexuality and sado-masochism - although it would perhaps be going too far to suggest that these "states" are autonomously chosen). There must therefore be some value to autonomous beings in non-moral, and possibly immoral, activities. Autonomy then may be said to be neutral in two senses. It is a condition of moral activity such that anyone who is to be a moral agent requires to be autonomous; and it is a source of value such that in order to give one's own life meaning, one must be able to fashion one's life for oneself, that is, one must (again) be autonomous.

We begin the following chapter by (in **section i**) locating our discussion of autonomy in the context of a tradition of political theory. If our account of autonomy is to be practically useful (rather than merely of theoretical interest) it might be useful at least to indicate how it relates to contemporary political discourse. This will be done through a consideration of two broad traditions of political thought the 'liberal' tradition, and the 'marxist' tradition. **Section ii** relates autonomy to liberty, while **sections iii** and **iv** continue the attempt, begun in this chapter, to contextualise our account of autonomy through a consideration of the notions of independence and rationality. The final two sections of the chapter situate autonomy in relation to persons, and especially through the notion of the body. The point of this is to avoid 'intellectualising' autonomy. It also allows us to introduce the notion of health, for if the body is an important aspect of autonomy, then health and its opposite assume importance within the context of our discussion of social policy.

Chapter III: Autonomy and Health

III. Introduction

In the previous chapter we established that personal autonomy is a necessary condition of moral agency. It is in this admittedly weak sense that personal autonomy is to be viewed as neutral amongst contending moral theories. Personal autonomy is not itself a moral concept. It is necessary for moral agency in the same way that the having of a body is necessary for moral agency. Neither personal autonomy nor having a body is sufficient in itself for moral agency. Bodies, as such, are not moral agents, but even bodies invested with the capacity for autonomy are not moral agents, for they are still too abstract. Autonomous individuals require a context in which to be moral, and this was the point of the discussion, in the final three sections of the previous chapter, where we attempted, through a discussion of Joseph Raz's notion of 'social forms' to relate our account of personal autonomy to a social context. In the first section of this chapter, we relate the concept of autonomy to one particular, if diffuse, social form - liberal democracy. The point of this exercise is to indicate, albeit roughly, that there are good historical reasons for focussing on autonomy as a unifying principle for social policy. We mean to suggest in this opening section that such a focus would not be alien at least to the British political tradition. In order to do this, we shall distinguish between two historical traditions of political thought, relating our discussion of autonomy to each in turn. It might reasonably be argued that this discussion too readily forces a wide variety of political theories and traditions into two ill-fitting closets. This criticism is, of course, both valid and important, but for of a work of this size such drastic reductions are unavoidable. We merely acknowledge the fact here.

In **section ii** we examine the relationship between autonomy and liberty. In Chapter One, **section iii(c)** we argued that liberty was inadequate as an organising principle of social policy. It is nevertheless the case that a number of writers appear to conflate autonomy with liberty, and especially with Berlin's account of positive liberty. The relationship between the two concepts is clarified. In **Section iii** we examine the notion of independence in the context of our account of personal autonomy, and in **section iv** the relationship between autonomy and rationality. In both cases our intention is to build on our previous argument that autonomy (whether personal or moral) makes little sense unless it is contextualised. The problem that is identified in relation to both independence and rationality is the tendency to view persons as self-contained. In these two sections it is contended that the very idea of what it is to be a 'person' involves references to a context beyond mere independent or rational beings. In **section v** this contextualising of the autonomous person is explored through a discussion of the - quite literally - embodied nature of autonomy. The body, it is argued, is the primary means of enacting one's autonomous decisions, so that the condition of the body might reasonably be held to have some effect upon one's capacity for autonomous behaviour. Through a discussion of the unity of the person we avoid an 'intellectualist' account of autonomy, and also open the way for the discussion of the relationship of health to autonomy undertaken in **section vi**.

III.i: The Idea of Autonomy.

Concepts have histories, and autonomy is no exception. The word 'autonomy' is of ancient Greek origin and referred, in that context, to city-states rather than to individuals. Although the concept survives in much the same sense today - we still talk of the autonomy of states - it can reasonably be said to apply to any social grouping or society that makes its own rules or laws. In its application to individuals, it can be traced back through the writings of Kant and Spinoza, the Philosophes, and at least as far back as St. Thomas Aquinas¹. A word of caution must inevitably be sounded about such exercises though, because the word 'autonomy' was not used by many of those whom it is claimed contribute to the history of the concept. Until fairly recently, only Kant appears to have used the word itself, and this with reference to his moral philosophy. The problem is that in constructing a tradition or a history one may make the mistake of forcing a set of diverse thinkers and philosophers into a conceptual straight-jacket, thus producing an appearance of coherence where, in reality, difference may be more in evidence. The problem may be illustrated in the following way. Autonomy is commonly said to invoke some notion of self-determination. Kant seems to have held that moral autonomy combines both freedom and responsibility, autonomous moral agents being those people who place themselves under the authority of rules that they have discovered (by the use of reason) for themselves². For Rousseau, on the other hand, it is obedience to laws that one has made for oneself that comprises, not

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1. Steven Lukes, Individualism, (Oxford: Basil Blackwell, 1973), pp.52-58
 2. Immanuel Kant, The Moral Law, Translated and Edited by H.J. Paton, (London: Hutchinson, 1956), pp.71-73

autonomy, but liberty³. Kant also places great emphasis on the importance of free will to the autonomous agent, but Hobbes, a thoroughgoing determinist for whom the idea of a free will was an absurdity, can also be said to have held that individuals are autonomous, in that they are the authors of their own lives and can be said to govern themselves⁴. If John Stuart Mill can be said to have had a theory of autonomy, it seems to have primarily consisted, not in conformity to rational laws but in non-conformity in the face of convention⁵. Even in a contemporary context, the term 'autonomy' is taken, by some moral and political philosophers, to be synonymous with liberty, sovereignty, self-determination, freedom of the will, and a wide variety of other ideas⁶.

Even where it seems apparent that the same concept is used, it would be rash to assume that the authors either understand or mean the same thing in their use of the term. According to MacIntyre, 'concepts are embodied

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3. Jean-Jacques Rousseau, The Social Contract and Discourses, Translated by G.D.H. Cole, (London: J.M. Dent, 1973), p.178. See also Andrew Levine, The Politics of Autonomy: A Kantian Reading of Rousseau's Social Contract, (Massachussetts: University of Massachussetts Press, 1976), pp.57-59
 4. Hobbes refers to the introduction of sovereignty by individuals as a 'restraint upon themselves' - Leviathan, Edited by C.B. MacPherson, (Harmondsworth: Penguin Books, 1951), p.223. In the state of nature, individuals are self-governing, and it is the right of self-government that is ceded to the sovereign on the implementation of the covenant (p.227).
 5. For Mill, conformity to 'the traditions and customs of other people' undermines one of the 'principal ingredients of human happiness' and hinders both the development of a person's character and social progress. John Stuart Mill, Utilitarianism, On Liberty, and Representative Government, Edited by H.B. Acton, (London: J.M. Dent & Sons, Ltd., 1972), p.115
 6. Gerald Dworkin, The Theory and Practice of Autonomy, (Cambridge: Cambridge University Press, 1988), p.6

in and are partly constitutive of forms of social life'⁷. If this is so, then it follows that 'different forms of social life will provide different roles for concepts to play'⁸. MacIntyre's argument is intended to emphasise the historical, social, economic and political context of concepts, and we shall be concerned to locate autonomy within the liberal democratic tradition. An alternative approach which need not necessarily emphasise the context of concepts is that proposed by Dworkin who suggests (following Hart and Rawls), that there is one concept, but many conceptions of autonomy, where the abstract notion ("autonomy" = "self-government" or "self-determination" or similar) may be filled out in a variety of ways⁹. Kant, Rousseau, Rawls, Sartre, Marx - all these people, for example, posit a self-determining being, yet all of these have very different accounts of what kind of being self-determination gives rise to. For Sartre, the self-determining being is a being condemned to freedom, a being for whom self-determination is a condition of anguish¹⁰. For Marx, human beings make themselves what they are through the kind of work they perform, yet there is an important

7. Alasdair MacIntyre, A Short History of Ethics, (London: Routledge and Kegan Paul, 1967), p.1. MacIntyre's concern is with moral concepts, but there seems no reason why his thesis should not be applied to concepts generally.

8. Ibid., p.2. This suggests a relativism about which MacIntyre is elsewhere more explicit. After Virtue (London: Duckworth, 1981) maps out the source of what MacIntyre sees as the inherent relativism of modern moral discourses (Chapters I-III) and outlines a solution based on a reading of Aristotle's account of the virtues coupled with a theory of tradition. See also **section iv** 'Autonomy and Rationality' pp.124-129 below.

9. Dworkin, op. cit., pp.9-10

10. Jean-Paul Sartre, Being and Nothingness, Translated by H.E. Barnes, (London: Methuen & Co., 1969)

sense in which human beings are not free to make themselves as they please, for the character of work is historically situated¹¹.

If it is accepted that thinkers as diverse as Hobbes, Kant, Marx, Mill, Rawls, Rousseau, and Sartre all have divergent theories of autonomy, then the claim that autonomy 'means' self-government, or self-determination, or whatever is true, but trivial. Focussing on the concept rather than the conceptions might also lead one to conclude that autonomy is less politically contentious than in fact it is. The claim that liberals (Kant; Rawls) and libertarians (Sartre, in his pre-marxist writings), communists (Marx) and 'possessive' individualists (Hobbes) all have some notion of autonomy underpinning their account of what it is to be human suggests that autonomy as such is devoid of ideological content. Yet it is clear that autonomy can be, and is, a politically problematic concept, and this can be illustrated by identifying two broad historical strands¹².

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11. "Men," says Marx, "make their own history, but they do not make it just as they please; they do not make it under circumstances chosen by themselves, but under circumstances directly encountered, given, and transmitted from the past" from "The Eighteenth Brumaire of Louis Bonaparte" in David MacLellan (Ed.), Karl Marx Selected Writings, (Oxford: Oxford University Press, 1977), p.300
 12. Bill Jordan, The State: Autonomy and Authority, (Oxford: Basil Blackwell, 1985); Lolle Nauta, "Historical Roots of the Concept of Autonomy in Western Philosophy" in Praxis International, (1985), Vol.4, pp.363-377. Both Jordan and Nauta identify two distinct traditions in this way, although Jordan is primarily concerned with the relationship between the citizen and the state, while Nauta is concerned essentially with the concept of autonomy itself. The notion of an 'exemplary situation' is Nauta's, pp.365-366

(a): The Liberal Tradition

The liberal tradition may be characterised by the 'exemplary situation' of the market, where the individual is taken to be, as it is claimed is the case with Hobbes, the 'proprietor of his own person'¹³. On this ground, the liberal tradition takes political obligation in civil society to rest on equal and voluntary exchange between individuals¹⁴. It therefore assumes some level of autonomy amongst citizens at the outset. The very concept of 'Liberal Man' is said to rest upon the notion of an 'autonomous and controlling' being who not only can but does choose his own life, or at least aspires to, and through such choices as he makes overcomes 'the contingencies of background, circumstance, and environment'¹⁵. What is more, he does this on his own, without waiting for the rest of the proletariat (or whatever) to catch up with him. The characteristic contemporary political configuration associated with the liberal tradition is liberal democracy, with its emphasis on the plurality of values, the primacy of the individual, and the voluntary nature of political obligation. Liberal democracy is said to be premised upon the claim that people ought to have the equal right to run their own lives free, as far as is possible, from interference by government or society, and in this it requires autonomous individuals¹⁶.

13. C.B. MacPherson The Political Theory of Possessive Individualism, (Oxford: Oxford University Press, 1962), p.3 & p.263

14. This point is made by MacPherson, op. cit., p.83 and also pp.272-274. See also Jordan, op. cit., p.9

15. Susan Mendus, "Liberal Man" in Philosophy and Politics, G.K. Hunt (Ed.), (Cambridge: Cambridge University Press, 1990), pp.46-47. See also Peter Binns, "Liberal Man: A Response" for a critique of Mendus, ibid., pp.59-76

16. For the characterisation of liberal democracy, see Carole Pateman, The Problem of Political Obligation, (Cambridge: Polity Press, 1979), pp.5-6; also C.B. MacPherson, The Real World of Democracy, (Oxford: Oxford University Press, 1966), pp.1-12. MacPherson considers liberal democracy to be inseparable from capitalism (p.4).
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This is not to say that autonomy is compatible only with liberal democracy. It has been suggested however that liberal democracies hold autonomy to be a 'quintessential value'¹⁷.

(b): The Marxist Tradition

With regard to autonomy, the marxist tradition differs from the liberal tradition primarily in locating autonomy in the future. The liberal tradition assumes some level of autonomy amongst individuals from the outset. In as much as the marxist tradition emphasises the alienation of individuals from their 'real' or 'true' selves, in as much as it asserts the exploitative nature of interpersonal relationships under capitalism, in as much as the free capacity to labour has become a necessity, in as much as labour, under capital, reduces human beings to performing a set of basic animal functions, then it has little or no room for autonomy amongst its premises. Indeed, for some marxists, to claim to be autonomous is to exist in a condition of illusion, and, as Marx himself put it, the 'demand to give up the illusions about their condition is a demand to give up a condition that requires illusion'¹⁸. For the marxist tradition, autonomy can reasonably be said to be the - or at the very least a - goal of political action and only possible when capitalism has

(Cont'd from previous page)

He also argues that the roots of liberal democracy lie in seventeenth-century political theory, commencing with Hobbes - MacPherson, The Political Theory of Possessive Individualism, pp.263-271. On this latter point, see also Pateman, op. cit., pp.11-14. See also Richard Lindley, Autonomy, (London: Macmillan, 1986), pp.7-10 for a brief account of liberal democracy in the context of a discussion of autonomy.

17. Lindley, op. cit., p.7

18. The 'Frankfurt School', for instance, exemplified by Herbert Marcuse, One-Dimensional Man, (London: Routledge and Kegan Paul, 1964), pp.19-20. The quotation is, of course, from Marx himself - "Towards a Critique of Hegel's Philosophy of Right: Introduction" in D. McLellan (Ed.), Karl Marx Selected Writings, (Oxford: Oxford University Press, 1977), p.64

been superceded by communism¹⁹. It has been suggested that, if there is a political configuration characteristic of the marxist tradition, then it is the centrally-planned, or communist model, where, it is said, the individual is subordinated to the interests of either the State or the community at large²⁰. There is, of course, dispute amongst marxists as to whether or not such a system existed. Those who denounced the USSR as itself a version of capitalism argued that it did not. If they were right, then the Soviet peoples were not then autonomous within the terms of the marxist model. We are content, at least for the purposes of this discussion, to leave this dispute to the marxists.

These two traditions, of course, serve to mask a wide range of very different political positions. For example, if the liberal tradition does indeed encompass 'liberal democracy', then the stark ideological contrast exhibited by setting up the two models in the way that we have shown runs into difficulty. Liberal democracies, since they are characterised by a plurality of values, themselves encompass a wide range of political positions including conservatism, liberalism, social democracy, socialism, communism, Raving Loonyism and many others. There are, of course, other ways in which the two traditions may be characterised. It has been suggested, for instance, that within liberal

19. Eugene Kamenka, Marxism and Ethics, (London: MacMillan, 1969), p.12. But see also Richard Archer, "Personal Autonomy and Historical Materialism" in Radical Philosophy, (1976), No.15, who argues that the working class must be autonomous if they are to achieve freedom in communist society (p.11). Archer equates revolutionary consciousness with autonomy. This has the advantage over the liberal tradition in that it suggests that autonomy can be a collective phenomenon, although it also leads easily to the Leninist conclusion that the autonomous (those who have achieved revolutionary consciousness) comprise an elite, distinct from the mass who have not.

20. Jordan, op. cit., pp.9-10

democracies there is characteristically a concern to mark out a realm of activity which is private and into which government may not enter, and there is a concern to protect what Berlin has called 'negative' liberties (freedom of speech; freedom of the press; freedom of thought) which themselves ought not to be restricted by governments²¹. By implication, the marxist tradition is concerned less with negative liberties than with so-called positive liberties which focus on entitlements. It is, of course, clear that this account of liberal democracy is idealistic. The realm of private activity varies from one liberal democracy to another, as does the nature and extent of the so-called 'negative' liberties. It must therefore be borne in mind in the subsequent discussion of health policy that this is not a comparative study but a study of an area of British social policy. That there are sometimes wide variations in the actual character of liberal democracies need not present us with any difficulties.

We have so far suggested that some level of autonomy is assumed by liberal democratic theory. This suggests two separate, though connected, issues. Firstly, it raises the question of what level of autonomy is to be considered adequate for an individual to function as a member of society? Full autonomy might, for example, be an ideal, and therefore possibly unattainable. But social policy, it would be realistic to suppose, must restrict itself to what is possible. Where then, and by what criteria, should the line be drawn? The second, and perhaps more fundamental question requires us to specify in more detail than we have done, what it is to be autonomous; for if we have no understanding of

21. Isaiah Berlin, "Two Concepts of Liberty" in Four Essays on Liberty, (Oxford: Oxford University Press, 1969), pp.122-131 for the discussion of negative liberty.

what autonomy is and what conditions it requires in order to sustain itself, then social policy will have nothing to get to grips with. There may be many things that autonomy requires, but our aim in this chapter is to consider the specific issue of health. It will be recalled that Plant et al include freedom from ill-health amongst their list of basic needs. Freedom from ill-health is a basic requirement of autonomy. It is also true that, in most liberal democracies, health-care consumes a larger portion of public revenue than any other single policy area. This is no less true of the United Kingdom. We shall begin therefore with a review of some accounts of autonomy, and especially that offered by Berlin, in order to ground our discussion of health and its connection with autonomy.

III.ii: Autonomy and Liberty

There are many ways to define autonomy. We have already considered, at some length, the claim that autonomy consists in 'the freedom to act morally' and have argued that this should be understood as only a partial account of autonomy. There are many other definitions open to us, from the simplest and most direct rendering of the Greek original - 'self-rule', or 'self-government' - to the rather more complex account offered by Berlin in his essay 'Two Concepts of Liberty':

I wish my life and decisions to depend on myself, not on external forces of whatever kind. I wish to be the instrument of my own, not of other men's, acts of will. I wish to be a subject, not an object; to be moved by reasons, by conscious purposes, which are my own, not by causes which affect me, as it were from outside. I wish to be somebody, not nobody; a doer - deciding, not being decided for, self-directed and not acted on by external nature or by other men as if I were a thing, or an animal, or a slave incapable of playing a human role, that is, of conceiving goals and policies of my own and realizing them... I wish, above all, to be conscious of myself as a thinking, willing, active being, bearing

responsibility for my choices and able to explain them by references to my own ideas and purposes.²²

This definition is interesting, because Berlin is not offering an account of autonomy at all, but of 'positive liberty'. In his essay, Berlin identifies a concern for positive liberty with political theorists such as Rousseau, Hegel, and Marx. It might therefore seem more appropriate to situate positive liberty within the marxist tradition described above. Berlin identifies negative liberty with political thinkers such as Hobbes, Locke, Constant, Tocqueville and John Stuart Mill²³. In other words, negative liberty - defined as the absence of external constraint - is to be identified with the liberal tradition. But one might reasonably object at this point that autonomy has now been identified exclusively with the marxist tradition. How can this be? There are two ways in which one might respond to this.

One response would involve breaking down the negative/positive dichotomy, and we have already considered one way in which this might be done²⁴. It is also possible to blur the overly-neat distinction that Berlin makes between the two concepts and their respective traditions. Although John Stuart Mill is firmly situated in the liberal tradition, it is clear that his conception of liberty involved more than protecting

22. Berlin, op. cit., p.131. Amongst those who take this to be an account of autonomy are Dworkin, op. cit., p13; Lindley, op. cit., p.6; Lukes, op. cit., p.55. Robert Young, on the other hand, argues that accounts of autonomy generally have more in common with Berlin's account of negative liberty in that they appear to see autonomy in terms of 'freedom from' interference by others. Young, Personal Autonomy: Beyond Negative and Positive Liberty, (London: Croom Helm, 1986), pp.7-8

23. Berlin, op. cit., pp.123-125

24. Gerald MacCallum, "Negative and Positive Freedom" in Laslett; Runciman; Skinner (Eds.), Philosophy, Politics and Society, Fourth Series, (Oxford: Basil Blackwell, 1972), pp.174-193. See Chapter One, section iii(b), pp.38-41.

individual actions from interference by other individuals. It is true that the essay On Liberty focusses on what, for Berlin at any rate, are the classic negative liberties - freedom of thought, speech, and publication. But Mill also recognised that mere absence of interference was inadequate as an account of liberty. Mill seems to have understood that people require and ought to be entitled to resources, especially education, in order to make the most of their liberty²⁵. Mill, in other words, recognised no distinction between negative and positive liberty²⁶. Thomas Hill Green, on the other hand, did distinguish between negative and positive liberty, but recognised explicitly (as Mill seems implicitly to have done) that a full account of liberty requires both aspects²⁷. The distinction may be further undermined if one accepts that negative liberties might themselves be re-cast as entitlements, or positive liberties, and vice versa²⁸. We have already suggested that the right to freedom from ill-health amounts to an entitlement to health-care. Similarly, both Mill and Green would presumably agree that the right to freedom from ignorance amounts at least to an entitlement to education. If this is accepted, it is possible to situate positive liberty (and hence, on this reading, autonomy) within the liberal tradition. In fact, Berlin himself appears to conflate the two senses of liberty. If we look closely at his definition of positive liberty we find that it subsumes also the notion of negative liberty. 'I wish,'

25. John Stuart Mill, "On Liberty" in Utilitarianism, On Liberty and Considerations on Representative Government, Edited by H.B. Acton, (London: J.M. Dent, 1972), pp.160-163. See also John Gray, Liberalism, (Milton Keynes: Oxford University Press, 1986), p.59

26. John Halliday, John Stuart Mill, (London: George Allen & Unwin, 1976), p.115

27. Thomas Hill Green, "Liberal Legislation and Freedom of Contract" in Harris; Morrow (Eds.), T.H. Green: Lectures on the Principles of Political Obligation and Other Writings, (Cambridge: Cambridge University Press, 1986), p.199

28. MacCallum, op. cit., p.182, n.9

writes Berlin, 'to be the instrument of my own, not of other men's, acts of will' and, later, 'I wish to be... self- directed and not acted upon by external nature or by other men' (emphases added). It must also be said that breaking down the distinction between positive and negative liberty in the ways described also has the effect of blurring the distinction made between the two traditions alluded to.

The second response would require distinguishing clearly between the concept - or concepts - of liberty, and the idea of autonomy. But can this be done? Some of those writers who offer Berlin's account of positive liberty as a definition of autonomy thereby imply that there is no distinction between the two concepts, while others suggest that autonomy incorporates both negative and positive concepts of liberty²⁹. Dworkin, on the other hand, argues that, although the two concepts are closely related, liberty is not equivalent to autonomy. To conflate the two is to miss an important difference between the concepts because autonomy can be restricted in different ways and by different means than liberty. Deception is a case in point. It is possible, argues Dworkin, to restrict a person's liberty by shutting him in a cell. However, if one only deceives that person into believing that the door is locked when, in fact, it is left unlocked, then one is not restricting that person's liberty since that person is free to leave. One is, however, restricting that person's autonomy. 'Deception,' says Dworkin, 'is not a way of restricting liberty.'³⁰. This is unconvincing for it rests on the view of liberty as the absence of external constraints - the negative view. The person in the cell is free, because there is no external

29. Lindley, op. cit., p.6; Young, op. cit., pp.3-6

30. Dworkin, op. cit., 14

restraint on his ability to leave. This ignores that the source of the deception is itself external to the agent, so that the prisoner's inability to leave might itself be understood as a failure of negative freedom. It is also possible to interpret negative freedom as freedom from interference by other people³¹. Yet clearly the prisoner is the subject of interference by another person. The deceived person, Dworkin claims, 'will feel used, will see herself as an instrument of another's will'³². This too suggests that we have here an account of the failure of negative rather than positive liberty. Either way, it seems erroneous to claim that deceiving someone does not restrict their liberty.

The terms 'autonomy' and 'positive liberty' might be interchangeable, but (bearing in mind the previous discussion) whichever term one employs, negative liberty - freedom from interference; freedom from compulsion or restraint - will be required in some measure. The prisoner may be 'free' when deceived into erroneously believing the prison door to be locked, but locking the door does not make the prisoner autonomous. The relationship between negative liberty and autonomy (or positive liberty) could be envisaged as concentric circles, where negative liberty is contained (and necessarily so) within the larger circle of personal autonomy/positive liberty³³.

31. MacCallum, op. cit., p.181

32. Dworkin, op. cit., p.14 (emphasis added). Of course, they will only feel used once the deception has been revealed to them, which is to say when they are no longer deceived.

33. The same argument is also applied by Dworkin to coercion (ibid.). But see also Joseph Raz, The Morality of Freedom, (Oxford: Clarendon Press, 1986), pp.154-156. Raz argues that coercion might sometimes be justifiable precisely in order to secure the conditions of autonomy.

III.iii: Autonomy and Independence

It is tempting, at this point, to see the distinction between freedom and autonomy as a distinction between external and internal phenomena. Freedom - and this may be said of both negative and positive liberty - might be thought of as an aspect of an individual's relationship to the world, and the people in it, about him (or her), while autonomy might be thought of as a kind of internal, intellectual activity, a relationship one has to oneself. Frankfurt, for example, suggests that what distinguishes human beings from other animals is their capacity to form desires about their desires³⁴. Animals as such are 'wantons' acting always on their most immediate desires - when they are hungry, they eat; when they are tired, they sleep, and so on (although this remains unproven). They are free to the extent that they can satisfy their desires, but they are not autonomous because they lack the necessary intellectual or critical faculties. Human beings, because they do possess such faculties, may have a desire to eat but they can also develop a higher-order desire not to eat, because they are fasting, or are on a hunger-strike. Human beings, in other words, can have desires about their desires; they can self-consciously re-order their preferences. The idea that autonomy is something wholly internal to the agent invokes the notion of a split-level or 'higher' self, where higher self is taken to be more 'real', more authentic. This has been described by Berlin as 'the retreat to the inner citadel'³⁵. It is a form of rugged individualism, which sees any influence on an individual as somehow malevolent, as diminishing autonomy. In terms of political

34. Harry Frankfurt, "The Freedom of the Will and the Concept of a Person" in G. Watson (Ed.), Free Will, (Oxford: Oxford University Press, 1982), p.82; also Dworkin, op. cit., p.15

35. Berlin, op. cit., pp.135-141

theory, the result, for some adherents of this view, is anarchism of the kind advocated by Robert Paul Wolff³⁶.

Wolff's position has been criticised as untenable and possibly incoherent. Wolff's argument is designed to show that obedience to authority can never be justified, hence the State can never be legitimate. But he seems at times to suggest that all obligations, even self-imposed ones, restrict one's autonomy and are therefore illegitimate³⁷. If this were true, then social life would either be impossible or insufferably Hobbesian. What is more, many of the relationships that we form, and which give our lives meaning, involve obligations and duties that we willingly - even autonomously - accept, value and enjoy³⁸. Contracts of employment set up formal obligations between employers and employees, yet many people value the jobs they do, and highly. Similarly, marriage may be viewed as a contract between two people that results in duties and obligations to one's spouse. One's freedom may be quite seriously curtailed by such a contract but - shotgun weddings (and possibly some arranged marriages) aside - these are restrictions that one willingly accepts and imposes on oneself.

36. Robert Paul Wolff, In Defence of Anarchism, (New York: Harper and Row, 1970)

37. '[A] promise to abide by the will of the majority creates an obligation, but it does so precisely by giving up one's autonomy', op. cit., p.41. Wolff's argument is to be distinguished from other libertarian arguments which suggest that we always act autonomously, or that autonomy can never be diminished. See, for example, Jean-Paul Sartre, op. cit., p.441

38. Raz suggests, for example, the relationship between children and their parents, a relationship not freely chosen (at least not by the children) but often willingly embraced, op. cit., p.369. See also Bill Jordan, Rethinking Welfare, (Oxford: Basil Blackwell, 1987), pp.17-18

Wolff's account of authority has been criticised as being too strong (it appears to consist in obeying commands just because they are commands) and he ignores the many kinds of authority to which we may be subject³⁹. For example, it has been suggested that it is perfectly compatible with the idea of autonomy, on appropriate occasions, to relinquish authority. One might autonomously (free from deception, coercion or manipulation) decide to join the army, thereby willingly placing oneself under the authority of a hierarchy of commanding officers. One may also, by the same token, enter into a social contract without thereby diminishing one's autonomy (although one may diminish one's liberty by doing so, as Hobbes recognised). Wolff would be on firmer ground were he to argue that, since the majority of people (and possibly everybody) in the world had not deliberately and willingly entered into a contract with their governments, no state was in fact legitimate, although this would not preclude such a state from coming into existence. One may also accept, and act upon, information received from people whom one has good reason to believe are better placed to understand the complexities of an issue, or who are trained in some way that the recipient of that information is not⁴⁰. Such might be the case with a member of the medical profession (we shall return to this issue in our discussion of the phenomenon of medicalisation in Chapter Four). Indeed, in a complex society such as ours, it would be difficult to conduct our lives if this were not the case, for 'the chain of testimony can only be as strong as the first-hand knowledge to which it is anchored'⁴¹. Few of us have either the

39. Dworkin, op. cit., discusses Wolff, pp.25-29

40. John Benson, "Who is the Autonomous Man?" in Philosophy, (1983), Vol.58, pp.6-7

41. Do we even accept the source documents, or must we conduct the experiments or research ourselves in order to verify it?. Benson, op. cit., p.7

time, the inclination, the financial resources, or the relevant knowledge of where to look in the first place to check the truth of every proposition that comes our way. There is also good reason to think that, if this were necessary for autonomy, then paradoxically our status as autonomous individuals would itself be diminished. If every proposition had to be checked for authenticity in this way, there would be little time to engage in the many other activities we might otherwise consider worthwhile⁴².

Such a level of independence is incoherent for another reason. When, for example, the Government issues a piece of advice concerning health, it is likely to be based on an interpretation of the available evidence. It is highly unlikely that this evidence will be conclusive. It will itself have required interpretation by those familiar with the methodological pitfalls and other areas of dispute and uncertainty within the field of enquiry. In other words a judgement will have to be made by the 'experts' concerning the relative merit of a body of evidence. If one were, in the interests of autonomy, to acquaint oneself with the sources and the various problems of interpretation, one would then have to judge for oneself the merits and demerits of the evidence. But, of course, one may also exercise one's judgement concerning the end product of the experts' judgemental process - one may judge the merits or demerits of the advice offered by the Government. To go to the original sources is not often, if ever, to cut through to the 'truth' of the matter. It may result in 'certainty' - the certainty delivered by the Government -

42. This predicament is well-captured by Raz's example of the Hounded Woman (op. cit., p.374) who, despite the fact that all her faculties are constantly engaged in avoiding the animal that constantly hunts her, does not live an autonomous life.

being undermined. Either way, one may exercise one's judgement concerning the relative worth of a proposition at a number of levels. The real danger to autonomy comes, not from surrendering authority as such, but from the uncritical acceptance of authority⁴³.

The 'rugged-individualist' account of autonomy (as this may be described) cannot adequately encompass what it means to live in a society. We saw in the previous chapter that it makes little sense to conceive of individuals as other than social beings. It is not that individuals form their desires in some private 'inner citadel' and then take them into the social sphere (where they are likely to be thwarted by other individuals who have formed their own plans and projects). It is rather the case, as Raz suggests, that the plans and projects individuals have are formed from inside a social context; they are, in fact, drawn from that context. We suggested, extending Raz's argument, that it is almost, if not entirely, impossible to conceive of individuals outside of a social context. Even the anti-social define themselves in terms of the social. It is inevitable therefore, that our autonomy is going to have a social element. It cannot be the case that autonomy is an internal phenomenon. Insofar as we are situated in a social context, our autonomy must be so too.

43. Benson, op. cit., p.6

III.iv: Autonomy and Rationality

There is another notion often associated with the idea of a 'higher' self, or an 'inner' self, or even a 'real' self. This is the notion of the rational self. Philosophically, the notion of the rational self, like the notion of autonomy, has a long history. It can, for example, be traced back to the ancient Greeks where something like it can be found in the Platonic theory of the Forms. Its clearest modern exponent was Rene Descartes, for whom the rational self (comprising of the mind, or the soul) was the more fundamental mode of being. The rational self was logically more fundamental than the body, for, after all, the rational self would survive the body in death. Although Kant was concerned to subvert the radical distinction between mind and body (through uniting empiricism with rationalism), nevertheless, in his moral philosophy he is undoubtedly a rationalist, for the Moral Law is to be discovered by reason, not experience. In this distinction is also to be found the notion that, in order to approach nearer to the 'self', one must shed those aspects of one's person that are irrational, such as the emotions - a view famously opposed by Hume⁴⁴.

Now, the autonomous person requires rationality⁴⁵, but this does not mean that the autonomous person has to be purely or wholly rational. The rationality that is required by the autonomous person, at times, need only be of the practical variety, involving the assessment of means towards an end or goal one has set upon. But this kind of calculating

44. Hume describes reason as 'the slave of the passions' in A Treatise of Human Nature, Edited by L.A. Selby-Bigge, (Oxford: Oxford University Press, 1978), p.415. Lindley, op. cit., discusses Hume's account of deliberative rationality at length, pp.28-43

45. S.I. Benn, "Freedom, Autonomy and the Concept of a Person", Proceedings of the Aristotelian Society, (1976), Vol.76, p.124

rationality, of itself, is not a sufficient account of what rationality might involve for the autonomous person. After all, animals seem often to exhibit this kind of rationality - the cat stalking a bird, or winding itself around its owner's legs, are both examples of behaviour designed to procure the satisfaction of its hunger. The problem for the autonomous person, is that the goals he or she has might not be their own, they might have been implanted - by a hypnotist, or by the capitalist economic system - or they might be the result of some compulsion. The neurotic who compulsively washes his hands might employ a very low-level of practical reasoning in working out the best way to perform his repetitive task, or he may employ a significantly higher-level of practical reason if his habit is such that he requires to conceal it in order to maintain the appearance, to neighbours, friends, or family, of normality. The neurotic may be employing a relatively high level of practical reasoning in this sense, but he would not be thought autonomous.

Autonomy requires that a person be able to give a reason or reasons for pursuing the goals, aims, plans, or projects they pursue, or the acts they perform, or attempt to perform⁴⁶. Yet this too should not be over-estimated, for the kinds of reasons required to justify an act will differ from one situation to another. MacIntyre has suggested that all reasoning takes place within the context of an 'historically extended, socially embodied' tradition⁴⁷, although it is unclear as to what a tradition might be. He is clear, however, that the concept of the self is partly drawn from the traditions into which one is, as it were,

46. Young, op. cit., pp.10-12; Rawls, op. cit., pp.408-410; Weale, op. cit., pp.45-47

47. MacIntyre, After Virtue, p.207

inserted. But it is also in part constructed, in narrative fashion, by the person his- or herself⁴⁸. This 'narrative concept of selfhood'⁴⁹ recalls our discussion, in the previous chapter, of social forms, for it implies that even the rational self is, for MacIntyre, defined in social terms:

If the narrative of our individual and social lives is to continue intelligibly... it is always both the case that there are constraints on how the story can continue and that within these constraints there are indefinitely many ways that it can continue.⁵⁰

Rationality is tied then to historical and social contexts. In a purely Kantian world, it is irrational to act on a maxim that does not conform to the criterion of universalizability. Reasons, given for actions, that do not conform are not reasons at all. In a Barbara Cartland novel, on the other hand, a single reason - love - motivates and explains in their entirety the actions of the protagonists. Stretched between the two extremes is our own world. Sometimes an emotion may be an acceptable reason for performing an act, and sometimes it may be inadequate. It is reasonable to do something for one person - a member of one's family perhaps - that one would not do for an outsider, on the basis that one loves that person. It would also be acceptable, if asked why one loves that person, to offer, as a reason for doing so, that they are a member of one's family. It would possibly be irrational for an adult (though perhaps not for a child) to push for further reasons. The autonomous person does not necessarily have to be an intellectual - the autonomous life does not require the level of argument and justification found in academic treatises, neither is it the case that human actions require

48. Ibid.., p.194

49. Ibid.., p.202

50. Ibid.., p.201 [second emphasis added]; On constraints on autonomy, see also Raz, op. cit., p.155; Weale, op. cit., p.50

chains of reasoning of the kind to be found underpinning logical proofs⁵¹. A certain consistency in one's actions may be all that is required⁵².

Reason is also important to autonomy in another sense, in terms, that is, of the capacity for critical reflection. According to Benn, the autonomous life is marked by a 'continuing process of criticism and re-evaluation'⁵³. This does not mean that the autonomous person must continually and incessantly undertake a review of his or her belief-set for, as with the neurotic who constantly washes his hands, this would seriously restrict autonomy. All that need be required is the disposition to resolve incoherences in one's life by 'rational reflection'⁵⁴. The person who uncritically accepts what he or she is told by other people is not autonomous. The person who accepts what other people tell them without good reason is acting, we may say, irrationally - although the 'good reason' requirement must be flexible enough to cope with the fact that information-gathering is a costly business. It is rational therefore to hold a belief for which one lacks hard evidence, or pending further investigation⁵⁵. It would, however, be irrational to hold on to such a belief if one were to discover that it was based on error or mistaken inference. Full rationality then is not necessary for autonomy, but lack of rationality seriously impairs one's

51. Young, op. cit., p.11

52. Roy Edgeley, Reason in Theory and Practice, (London: Hutchinson, 1969), p.18

53. Benn, op. cit., p.124, echoing Socrates' remark, in The Apology, that the unexamined life is not worth living, Plato, The Last Days of Socrates, Translated by Hugh Tredennick, (Harmondsworth: Penguin Books, 1969), p.72

54. Benn, op. cit., p.128

55. Lindley, op. cit., p.47

autonomy by impairing one's capacity for critical evaluation, and for making sense of one's life⁵⁶.

The crucial point which we have sought to stress in the foregoing discussion is that autonomy should not be seen as an isolated, internal quality of abstract individuals, the kind of individuals, that is, one reputedly finds in 'classic' liberal (and economic) theory. Just as individuals are embedded in a social context, so their autonomy will also be contextualised. This is why it makes sense to think of organisations, sects, societies, and perhaps even cultures (including, possibly but contentiously, 'dependency cultures') that do not value autonomy highly, whilst others do. What seems reasonably clear, however, is that a society that lacked autonomous members - a society of autonomata - would hardly be a society at all.

There is, however, another dimension to autonomy which is implied by the contextualised account just given, for if autonomy is situated in the world, then it is related to that world. It is for this reason that, in order to be autonomous, one needs more than just the capacity for autonomy. One needs more than the capacity for critical or rational reflection; the capacity for ordering and re-ordering one's preferences, and so on. One also needs to be able to exercise one's capacities - autonomy is therefore an exercise-concept⁵⁷. If autonomy is valuable, it cannot be so merely because one possesses the capacity for it - it is

56. Lindley, op. cit., p.70; Young, op. cit., p.12

57. Charles Taylor, "What's Wrong with Negative Liberty?" in Alan Ryan (Ed.), The Idea of Freedom, (Oxford: Oxford University Press, 1979), p.177

rather, as Raz suggests, that its use makes it valuable⁵⁸. In order to be autonomous, one must be in a position to make effective in one's actions the choices one makes as the result of one's reflections and evaluations⁵⁹. This in turn implies that in order to be autonomous, one must be in a position to choose from a range of possible - which is to say achievable - options. There must be a range of options, because a choice of one is not a choice at all. But quantity is not of itself important - there must be variety too⁶⁰. It is here that liberty is important to autonomy, for one must be free to implement one's choice when one has made it. It is this - the implementing of one's autonomous choices - that we shall understand as exercising one's autonomy. It is important to recognise this in order to avoid falling back into the intellectualist trap. A choice that one cannot implement is not a choice at all.

58. Raz, op. cit., p.372; but see Lindley, op. cit., pp.68-69 who suggests that it is desirable to distinguish clearly between the capacity for and the exercise of autonomy, although he does not think this desirable when one is concerned - as we are - with social policy

59. Dworkin, op. cit., p.17; Frankfurt, op. cit., pp.89-90

60. Raz, op. cit., pp.374-375

III.v: Autonomy, Health, and the Unity of Persons

We have so far been at pains to stress the social nature of the autonomous person. The importance of this lies partly in giving an adequate account of autonomy, in acknowledging, that is, some of the limitations of the concept, but also partly in laying down a foundation upon which to build a substantive body of social policy. We are, after all, interested in the possibility of employing autonomy as a unifying principle for social policy. It is important therefore to understand the nature of the concept, the better to construct that policy. This is certainly true of the specific area of policy - health - with which we shall be concerned in the remainder of this work. The tendency to view the person as comprising of two distinct parts - body, and mind (or soul) - received its classic statement in the work of the French philosopher Rene Descartes⁶¹. The legacy that Descartes has bequeathed us has survived in the notion of the 'rational' self, or the belief in an 'inner citadel'⁶². To read an account of autonomy onto such a conception would have important consequences for the kinds of health policies one develops. For Cartesian dualists, it is conceivable that one's body could suffer great harms without in any way affecting one's mind or, since autonomy is a feature of the mind, one's autonomy⁶³. If

61. Descartes, esp. "Second Meditation: The Nature of the Human Mind" and "Sixth Meditation: The Existence of Material Things", in Elizabeth Anscombe; Peter Thomas Geach (Eds.), Descartes: Philosophical Writings, pp.66-75 & pp.109-124 respectively. Translation by the Editors.

62. Gilbert Ryle's attack on the Cartesian 'myth' is amongst the most strident of its kind. Ryle, The Concept of Mind, (Harmondsworth: Penguin Books, 1963), pp.13-25

63. For Descartes, the body (matter) is caught in a deterministic chain of cause and effect. It cannot therefore be autonomous. The mind, however, is free from causal pressures and can be autonomous - although it is difficult to see how, if this is the case, the mind can exercise any control over the body. It is, to use Ryle's expression, a 'ghost in a machine'.

autonomy were a purely mental phenomenon, then one might conclude that the only form of health care that could be derived from employing autonomy as a unifying principle of social policy would be psychiatric care. The point of such care would be to restore as quickly as possible one's ability to reason in order that one may once again take control of one's life. We have, in the preceding section, attempted to establish that, despite - perhaps even because - of its employment of reason, autonomy is a social phenomenon. Post-Cartesian dualism cannot be made easily to fit the description of the autonomous person we have sought to develop. The mind - whatever this might be - is not separate from the body, and even if we concede to the dualists that mind and body are distinct substances, it remains the case that they interact closely. What happens to the body will have some effect upon the mind, and vice versa. It has been recognised only recently in the field of sociology that, for human beings as social actors, the body is an integral medium of 'self-presentation, personal control, and identity'⁶⁴. Even for those who hold the dualist view, it must be accepted that the body we have is the most social of our primary aspects - it is clearly and uncompromisingly located both temporally and spatially, while the mind - at least for Cartesian dualists - is neither of these things⁶⁵.

64. Peter E.S. Freund, "Bringing society into the body: Understanding socialized human nature" in Theory and Society, (1988), Vol.17, p.840. Freund is referring at this point to the work of Erving Goffman.

65. The difficulty for the Cartesians is that, if my mind is neither temporally nor spatially located, then there seems to be no reason to believe that it is in my body, or indeed any body. Paradoxically, Descartes himself believed that the mind (i.e. the soul) resided in the pineal gland, which at least suggests that it is located in space.

For the Cartesians, the mind governs the body. But even if we accept the dualist premise it is clear that the body can sometimes 'govern' the mind. For example, it is now recognised that pre-menstrual tension, which has its origins in the physical, can have seriously debilitating effects on the mental. That 'chemical castration' is an acknowledged treatment for sex-offenders also suggests that some personality-traits are driven by the physical (or, in both of these cases, the hormonal). It is not just hormones that have the capacity to alter a person's behaviour. High blood-pressure can make a person tense, even angry⁶⁶. It is, of course, difficult to be specific as to how such phenomenon might affect a person's autonomy. It might, for example, depend on the extent to which one's normal behaviour-patterns, or personality traits, are disrupted. This in turn requires some understanding of what one's 'normal' behaviour-patterns, in fact, are. We shall return to the idea of normality shortly. But what we need to stress here is the extent to which changes in the physical aspect of a person will have some determinate effect on the mental aspect of that person. The process is not all one way, of course, for changes in the mental life of a person might also result in changes in the physical life, in terms of behaviour or personality traits. The depressed person can be lethargic, whereas he might previously have been energetic (although it is not unknown for depressed people to maintain a facade of 'normality'). The essentially simple point to be made here, however, is that the condition of the body impinges upon the mind, and vice versa, so that it is misleading to maintain a dualist account of the person, at least as far as health is concerned. Just as the positing of a 'rational self' described in the

66. At least anecdotal evidence exists for this claim. See Cannon and Einzig, Dieting Makes You Fat, (London: Century Publishing, 1983), p.155

previous section can be misleading, so too, in terms of health care, can be the sundering of the person into two irreconcilable substances, mind and body⁶⁷. Autonomy is, as we have stressed, a characteristic of persons, and persons are more than merely either minds or bodies. An adequate autonomy-derived health policy would have to recognise this, and would consequently have to treat of 'the whole person'.

One immediate difficulty with such a policy would be its scope. In order to understand what this difficulty entails, it will be useful to consider one particular account of how ill-health might affect one's autonomy. The example we shall employ will be drawn from Joseph Raz's The Morality of Freedom. Raz himself employs the example to demonstrate the way in which coercion can be said to restrict one's capacity for autonomy. However, the example may be adapted to illustrate one facet of the relationship between ill-health and autonomy. Raz suggests that autonomy rests not only on a capacity for choice, and of choosing between options, but also on the adoption of personal projects, the development of relationships, and the acceptance of commitments⁶⁸. The choices one makes and the projects, relationships and commitments that one adopts are (morally) valuable to the agent, and make that agent's life a life worth living. Raz ties the notion of a worthwhile life to a set of necessary conditions - he calls them 'personal needs' - and these are 'what is necessary to have the life one has or has set upon'⁶⁹. A pianist, for example, will need (amongst other things) a set of fingers;

67. It is worth recalling the etymology of the word 'health', which is derived from the Old English words 'hal' meaning whole and 'haelo' meaning wholeness. John D. Jago, "'Hal' - Old Word, New Task: Reflections on the Words 'Health' and 'Medical'" in Social Science and Medicine, (1975), Vol.9, p.2

68. Joseph Raz, The Morality of Freedom, p.154

69. Ibid, pp.152-153

a footballer (amongst other things) a set of legs, and so on. Coercion, for Raz, involves the intentional narrowing of a person's options, by another person (or set of persons), to the point where the choice made is dictated by the coerced person's personal needs. The pianist who is threatened with having his fingers crushed is not acting autonomously in choosing to obey his coercer, because in doing so he is dictated to by a personal need (given that the pianist values his ability and considers his chosen career a life worth living)⁷⁰. The more one's choices are dictated by personal needs, the less capacity for autonomy one has⁷¹.

Raz goes on to say that:

Of course natural conditions may also force people to make choices determined by the need to secure the necessities of a worthwhile life... An autonomous personality can only develop against a background of biological and social constraints which fix some of its human needs. Some choices are inevitably determined by those needs. Yet, harsh natural conditions can reduce the degree of autonomy of a person to a bare minimum just as effectively as systematic coercive intervention.⁷²

If it can be shown that health - or lack of it - aligns one's choices with one's personal needs, then it will be possible, at least tentatively, to conclude that there is a link between health and autonomy. In fact, this is relatively easy to do. Consider, since it is Raz's own example, the pianist. Suppose that this pianist one day discovered that the headaches from which he had been suffering for some time had been caused by a brain tumour. This, or so his doctor informs him, also explains the occasional numbness that he has experienced in his hands and fingers from time to time. The pianist is informed by his doctor that one likely effect of the brain tumour is paralysis of the hands, and that an operation would prevent such an eventuality. The

70. Ibid, p.153

71. Ibid, p.155

72. Ibid, pp.155-156

pianist (like most of us) dislikes the idea of an operation and of cancelling various performances that he has agreed to give. Yet, if he considers his career as a pianist worthwhile, then he really has few options. He is not coerced, since there is no intentionality involved on the part of the brain tumour. But his personal needs (fingers; ability to play the piano) can be said to 'dictate' his choice of action in agreeing to the operation.

This example shows that ill-health can affect one's autonomy. It would, however, be wrong to conclude from this that all manifestations of ill-health affect a person's capacity for autonomy. This is partly a problem of definition. The idea of ill-health is parasitic upon the idea of health, but it is unclear as to what we are to understand health to be. It is possible, for example, to define health negatively - as the absence of disease or illness - or positively - as a 'state of complete physical, mental and social well-being not merely the absence of disease and infirmity'⁷³. The negative definition is problematic in itself, since it is now customary to distinguish between 'illness' and 'disease' - the former attaching to the experiential or subjective character of ill-health; the latter attaching to the objective character, where ill-health is tied to norms and criteria developed usually by the medical profession. 'Illness' is said to be a cultural phenomenon 'dependent on folk definitions of normality which may or may not have a relationship to biomedical definitions', while 'disease' is said to be 'independent

73. The quotation is from the World Health Organisation's 'Constitution Basic Documents 10th Edition' (1965), cited in Christopher Ham, Health Policy in Britain 2nd Edition, (London: MacMillan, 1985), p.162

of social behaviour'⁷⁴, though it must be said that such a distinction is difficult to maintain. The activities of the medical profession who provide 'biomedical definitions' are themselves an aspect of social behaviour, and as such may be located, in cultural terms, in modern industrial society. Distinguishing 'illness' from 'disease' in this way also means that it is possible to be 'ill' when no disease is present, and vice versa⁷⁵. This is one possible consequence of Parsonian definitions of ill-health. Parsons defines health in terms of one's ability to perform one's social roles - ill-health being an inability to fulfil one's obligations and duties as a social being⁷⁶. On Parsons' terms, one is ill if one is prevented from performing one's allotted roles by, for example, a broken leg. A broken leg is not a disease, but since remedy is sought through the medical profession then it is a medical problem⁷⁷. The example of the piano player, as it is employed here, suggests a variant on the Parsonian model of health and illness, where these concepts might be tied to autonomy through engagement with social forms (where social forms might serve an analogous purpose to

74. Judith Allsop, Health Policy and the National Health Service, (London: Longman, 1984), p.145

75. Allsop, ibid.

76. Parsons defines health as 'the state of optimum capacity of an individual for the effective performance of the roles and tasks for which he has been socialized. It is thus defined with reference to the individual's participation in the social system', Talcott Parsons, "Definitions of Health and Illness in the Light of American Values and Social Structure" in E. Gartly Jaco (Ed.), Patients, Physicians and Illness, Third Edition, (New York: The Free Press, 1979), p.132. A recent version of this appears in The Nation's Health: A Strategy for the 1990's, Edited by Alwyn Smith and Bobbie Jacobson from a report by an independent multidisciplinary committee, chaired by Professor Alwyn Smith, (London: King's Fund/Oxford University Press, 1988), where health is defined as the capability 'of meeting the obligations and enjoying the rewards of living in [one's] community', p.3

77. 'Medical' refers 'primarily to the treatment and curing of disease and the restoration of health', while 'health' means 'freedom from disease, pain and abnormality'. Jago, op. cit., p.2

Parsons' Durkheimian notion of roles). On this model, 'illness' would be defined as the inability to act autonomously through reasons which are attributable to the malfunctioning of the autonomous person's body - where, in view of the discussion in the previous section, 'body' is taken to refer to the whole person.

III.vi: Autonomy and Health Policy

The previous discussion has established two things: first, that autonomy is affected by health; and second, that it is affected by the health of a person viewed as a totality, and not just as a mind, an intellectual entity. It is not only the capacity for autonomy that can be affected by ill-health; one's ability to exercise one's autonomy might also be affected by ill-health. The account of autonomy that we have developed so far can be likened to Dworkin's 'weak' account. For Dworkin, autonomy is a condition of moral thinking. It is, therefore, a 'relatively weak and contentless notion'⁷⁸ because, if it is a condition of moral thinking, then no substantive moral principles follow from it. Our concern is not only with moral thinking, but also in what it takes to formulate possibly non-moral plans and projects. But if we adopt the weak account of autonomy, the question then arises as to what kinds of substantive policies - if any - might be derived from focussing on the relationship between health and autonomy? The remainder of this work will essentially be devoted to considering this problem, but for now we turn our attention to some of the preliminary difficulties in developing an autonomy-based health-policy.

78. Dworkin, op. cit., p.31. Dworkin distinguishes between the 'weak' concept of autonomy, and the substantive, Kantian conception of Moral Autonomy, ibid., p.47

There is one potential advantage derivable from our concern to employ autonomy as an organising principle for social policy. As it stands, the medical profession is obliged - in theory at least - to provide blanket coverage for ill-health amongst the population of the United Kingdom. One acknowledged problem with this situation is the difficulty of restricting demand for health care. Despite Beveridge's initial assertion that the cost of providing health-care would diminish over time as the health of the nation improved⁷⁹, the reverse has, in fact, been the case. One Minister of Health - Enoch Powell - stated (in 1966) that there is 'virtually no limit to the amount of medical care an individual is capable of absorbing'⁸⁰. There are a number of reasons for this including demographic changes - there are more elderly people now than there were when the National Health Service was established, and elderly people require more health care than their younger counterparts⁸¹ - and technological innovation - where the cost of diagnosing and treating disease has risen through the development and employment of high technology machinery and drugs⁸². People do not even have to be ill now to absorb medical care - one result of the diagnostic application of medical technology, and the screening programmes in which it is sometimes employed. The question is whether or not linking health to autonomy might provide some rationale for more explicitly restricting the distribution of finite resources than the rather ad hoc process that

79. Sir William Beveridge, Social Insurance and Allied Services, (London: HMSO, Cmd.6404, 1942), p.201; See also Brian Abel-Smith; Richard Titmuss, The Cost of the National Health Service, (Cambridge: Cambridge University Press, 1956), pp.1-2

80. Enoch Powell, A New Look at Medicine and Politics, (London: Pitman Medical, 1966), pp.26-27

81. Rising from around 6 million in 1961 to nearly 8 million in 1981 (in the 65 and over age-group). Source: DHSS, Growing Older, (London: HMSO, 1981), Chart 'A'.

82. Allsop, op. cit., p.40

appears to operate at present, where health professionals, or so it is sometimes claimed, are forced (and reluctantly) to make clandestine decisions as to who should be given priority and when in the face of tight budgets and the absence of official guidelines. If the notion of health were to be linked to autonomy, then it might be the case that, where a particular ailment had no appreciable effect on a person's capacity to exercise his or her autonomy, the state would not be required to fund such treatment as might be considered necessary. For example, it might be the case that the removal of unsightly tattoos will not have any effect on the autonomy of a person, while the removal of a tumour might have a significant effect on the same person.

But if this sounds initially plausible, there are substantial difficulties to be overcome before one could utilise autonomy in this way. To do so would not, for example, successfully bridge the gap between the objective and subjective accounts of illness. Objectively, it might be possible to draw up a list of ailments that theoretically impinge upon some model person's autonomy. But a model person is not an actual person, and what is damaging to one person's autonomy might not be so to another's. This is largely because, as we have already indicated, the way ill-health impinges upon a person's autonomy is tied to the particular life one has chosen for oneself. For a pianist, whose chosen life revolves around piano recitals, to lose his fingers is to lose his chosen life. For a footballer, the loss of the odd finger might not seriously affect the pursuit of his chosen career. It is not so much that an individual 'deviates' from some objective norm of health, for

what is 'normal' to one individual might be abnormal to another⁸³. For the novelist and poet Christopher Nolan 'normality' consists in complete dependence on other human beings; Nolan has known no other condition since he was deprived of oxygen during birth. Nolan's condition, however, would be severely abnormal for the athlete Daley Thompson⁸⁴. The difficulty is signalled by Raz's employment, in the example utilised above, of the term 'personal needs'. In Chapter One, we suggested that utilising the concept of need as an organising principle for social policy was problematic precisely because needs were tied to subjective factors. Furthermore, we suggested (following Plant et al) that focussing on the conditions necessary for the autonomous formulation of plans and projects might generate a set of basic needs shared by all autonomous (or at least potentially autonomous) agents. We seem to have turned full circle to arrive back at the problem we set out to solve.

The task is made more difficult by two further considerations. Firstly, in order to gauge, for each individual, how a particular ailment affected their ability to act autonomously, it would be necessary first of all to discover which aspects of their life they valued, and to what extent. This assumes that the policy-formulator will have the resources (time; money; labour-power) available to conduct the necessary interviews to determine such things. More problematically, it also assumes that individuals will be in a position to supply a clear-cut answer to the policy-formulator's query, and this may be assuming too much. Autonomous persons, as we have already suggested, do not necessarily need to have contemplated each choice they have made to

83. Andrew C. Twaddle, "The Concept of Health Status" in Social Science and Medicine, (1974), Vol.8, p.35

84. This point is discussed in Chapter Five, **section i**.

date. They need not have categorically ranked their preferences following a process of critical soul-searching and indeed the autonomous person, we may assume, reserves the right to alter the ordering of his or her preferences at a moment's notice, if they so wish, so that any list supplied to the policy-formulator would be far from definitive. It is also possible that, in the face of an illness, a person might radically alter his or her priorities. The person who ranked cigarette-smoking amongst her most pleasurable of activities might nevertheless decide to give this pursuit up on being told that she has a progressive smoking-related disease, in order to protect the level of health she currently has. Another person might decide that - disease or not - a life without cigarettes is a life not worth living.

The second difficulty arises if one views health as a resource, for there seems to be little reason why the autonomous person should not forego health in the cause of some autonomously-chosen pursuit. When Pete Townsend of The Who penned their hit record My Generation in 1965 he included the line 'hope I die before I get old'. What was important to Townsend then was not health or anything as fuddy-duddy as that. The things that were important to Townsend and others of his generation - scooters, drugs, sex, holding running battles along Brighton front etc. - were at that time more important than health or the prospect of a long life⁸⁵. Clearly, an important consideration to bear in mind in any discussion of health qua resource is that many pursuits (and not just the rock'n'roll lifestyle) involve some element of risk. That is to say, they involve potential harm to a person's health. Of course, this is not

85. This consideration connects with the first in that one's priorities change over time. Townsend would probably not endorse his earlier declaration now, having advanced in age.

usually why a person engages in risky behaviour. Smokers, for example, do not seem generally to derive an added thrill from their habit because there is a strong possibility of their contracting some form of serious or fatal disease. But if health is a resource that may be traded, it cannot be assumed that the person who decides, for whatever reason, to trade that good or at least to place it in jeopardy is thereby acting heteronomously. Soldiers who, during World War I, rendered themselves unfit for combat by maiming themselves - usually by shooting themselves in the foot - were deliberately and consciously trading their health for safety⁸⁶. This is to be distinguished from those instances where only the risk of ill-health is contingent upon the performing of some action. A person who indulges in hang-gliding and, through an accident, maims him- or herself, is not trading health for the enjoyment of hang-gliding. Indeed, it is entirely possible that the accident will prevent any pursuit of the sport in future. The difference appears to be one of deliberation and intent. The soldier deliberately maims himself; the hang-glider does not. The soldier intends to shoot himself in the foot; the hang-glider pilot does not intend to break his leg. Given that some people may be willing to trade health for other goods, it may be difficult to retain health amongst the basic needs necessary for autonomous behaviour.

But on the whole, neither the person who injures his- or herself partaking in some risky sporting activity (or similar) nor the person who contracts a disease, chooses their ailment. Unlike the soldier who

86. It could be said that the soldiers who maimed themselves in this way were trading health for health, where the injury consequent upon shooting oneself in the foot was to be offset against the strong possibility of a more serious disability - or even death - being inflicted upon one by the enemy.

maims himself, the injured hang-glider pilot did not choose to break his leg, and as such his injury can be said to thwart his autonomy. The soldier's injury serves some further purpose; the same is not true of the hang-glider pilot⁸⁷. Similarly, the person who develops multiple sclerosis does not choose to contract this debilitating disease (neither could they if they wanted to, although this is not true of all diseases). If we are to use the link between health and autonomy as a means by which to restrict the distribution of health-care resources, it would nevertheless be problematic to focus on the aleatory aspects of the relationship. There are considerable 'grey' areas, some of which have received attention recently, especially with regard to 'high-risk' activities such as cigarette-smoking, using other drug-addicts 'works', and having unprotected sexual intercourse with several partners. One crucial difficulty would be in establishing whether or not the person who indulged in any one of these activities understood the risk he or she was supposed to be taking. This would not be at all a straightforward task. It would be made more difficult if, as is often the case, the level of risk varied from locale to locale. Even if the smoker who contracts lung-cancer late in life had known the risk she was taking, it would still be illegitimate to conclude that she had intended to develop the disease as the soldier intended to damage his foot. There is also the medical problem of establishing anything more than a statistical connection between her habit and the disease. Just because someone who smokes develops lung-cancer does not mean that the smoking caused the lung-cancer. Smoking, after all, is not the only cause of the

87. It is possible, with hindsight, that the hang-glider pilot may come to appreciate breaking his leg. He might, for example, discover the delights of reading books whilst recuperating - an activity that his dare-devil lifestyle might until then have precluded.

disease - there are many non-smokers who contract smoking-related diseases.

Conclusion

We have sought, in this chapter, to contextualise our account of personal autonomy in order to overcome a number of difficulties generally associated with the idea of autonomy. Amongst the most important of these difficulties was the abstract, formal nature of the concept as it appeared in its Kantian, or neo-Kantian guises. In view of the project, set out in Chapter One, of employing some version of autonomy as an organising principle for social policy, it became important to substantiate our account of personal autonomy to avoid, as much as possible, the abstractions associated with moral autonomy. In Chapter Two, **sections iv** and **v** this aim was pursued through a discussion of the relationship between personal autonomy and social forms. In **section i** of this chapter, we continued this task by relating autonomy to one such (albeit diffuse) social form - liberal democracy - in order to distinguish our account of autonomy from the potentially revolutionary marxist account. Having located our discussion of autonomy within a liberal tradition of political theory, we proceeded, in **section ii** to consider the relationship of personal autonomy to what is usually taken to be a central concern of liberal theory - liberty. Having established the priority of autonomy over liberty, we then moved on, in **sections iii** and **iv** to counter the individualism sometimes associated with both autonomy-based and liberal political theories. Focussing on the idea of 'personhood' and building on our discussion, in the previous chapter, of social forms, we argued that the idea of the autonomous person can only be made intelligible through reference to a social

context. In **section v** we argued against the 'intellectualist' tendencies of some accounts of autonomy, by focussing on the unity of persons. In effect, we argued for a 'materialist' account of personal autonomy, where the body of autonomous persons assumes importance as the means through which they exercise their capacity for autonomy. This brought the condition or health of the body within the terms of our discussion of autonomy, and so within the scope of any social policy that utilises our account of personal autonomy. In the final section, we considered some of the difficulties for social policy that might be thought to follow from this account of personal autonomy.

Having established the importance of health to autonomy, we turn, in the next chapter, to consider a set of arguments which hold that aspects of health policy and of health care have the effect of diminishing, rather than restoring autonomy. These arguments focus on the phenomenon of medicalization.

Chapter IV: Medicalization and Autonomy

Introduction

In the preceding three chapters, an account of personal autonomy has been developed. This account suggests that if personal autonomy is to be employed as an organizing principle for social policy, then it is important to understand the relationship between autonomous choices and their implementation. Since the body is the primary means of implementing autonomous choices, the condition of the body must assume importance in any social policy that values autonomy. In other words, if personal autonomy is employed as an organizing principle, health becomes an important issue in social policy. In the next two chapters, this account of personal autonomy is set against two issues relating specifically to the field of health policy. However, before this task is commenced, it would be as well to say something about the shift we are making from the realm of theory to that of social policy.

In the introduction to this thesis, it was suggested that the role of theory in this work was intended to be 'fairly weak' (p.4). By this we mean that the account of personal autonomy developed thus far need not strongly suggest hard courses of action for social policy makers to adopt. As we stated in the Introduction, we understand the task of theory to be that of merely delineating the area in which political action may take place. There may, therefore, be plenty of scope within our theory of autonomy for political debate amongst adherents of many political persuasions. In this sense it might be said that our account of personal autonomy could conceivably transcend the boundaries within which the thesis has sought to locate itself - those of liberal political discourse. Whether or not this is so need not detain us here. What must detain us is the notion of a 'weak' rather than a 'strong'

theory. What does this distinction entail, and how is it to be utilised in the subsequent discussion?

A useful way in which to understand the distinction between weak and strong theories is through an analogy with the Popperian view of scientific endeavour. It has often been said that scientists seek truths about the world, where 'truth' suggests 'finality and certainty'¹. If a 'truth' could be discovered, then argument about that 'truth' would cease. Strong theories will admit of no further debate, or at least of very little debate, concerning their content and conclusions. Popper himself is aware of the implications of applying this analogy in the fields of social science and political theory. His claim is that strong social or political theories will tend to be authoritarian, stifling debate and hence also progress (Popper is fond of citing Marx in this context, although debate within marxist circles has not ceased altogether, as is attested by the bewildering variety of marxisms that exist in the world).

Popper's is an essentially pragmatic view of the role of theory in social science (and in science generally). However, it would be wrong to conclude that 'weak' theories, just because they are weak, are not therefore also prescriptive. They may be. But they differ from 'strong' theories in that their prescriptions are tentative in character. Bearing this in mind, our exploration of some of the implications of our account of personal autonomy will be conducted negatively. Instead of developing positive proposals based on the previous three theoretical chapters, we

1. Karl Popper, The Open Society and Its Enemies. Volume 1: The High Tide of Prophecy: Hegel, Marx, and the Aftermath, (London: Routledge, 1966), p.12.

shall 'test' two issues in the field of health-care against our theory of personal autonomy. On this basis, our approach, in the subsequent two chapters, will be essentially eliminative, ruling out possible courses of action but stopping short, in this work at least, of proposing alternatives.

IV.i: The Idea of Medicalization

We have argued that, although there may be difficulties in understanding the precise nature of the connection, health is nevertheless an important condition of autonomy. It might be thought therefore that the provision of health care could only enhance autonomy. There is however a substantial body of thought which argues precisely the opposite.

Although there are a number of different interpretations of the central thesis, the process said to be at work may be described by the single term 'medicalization'. The central thesis covered by this term is fairly straightforward - the word 'medicalization' refers to a process whereby the influence, authority, or power (or all of these) of the medical profession is said to extend or grow at the expense of individual autonomy¹. It has been suggested that there are, broadly speaking, three versions of the medicalization thesis². The first of these suggests that doctors, in the process of medicalizing society, act in their own self-interest, or in the interest of their profession. The second version suggests that, in the process of medicalizing society, doctors are simply responding to, rather than initiating, broader social processes. On this view, medicalization is either a by-product of the crises of capitalism (as Navarro suggests) or of some other social process (such as Ivan Illich's 'industrialism'). The third view is that in medicalizing society, the medical profession performs either a

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1. M. Morgan; M. Calnan; and N. Manning define 'medicalization' as 'The expansion of modern medicine into areas which were not previously within the medical sphere' in Sociological Approaches to Health and Medicine, (London: Croom Helm, 1985), p.22; while Ian Kennedy suggests 'the conversion of social and political ills into illnesses' in The Unmasking of Medicine, (London: George Allen & Unwin, 1981), p.13.
 2. Morgan, Calnan, & Manning, op. cit., pp.22-28.

policing function or a legitimising function, where, for example, access to statutory benefits may either be permitted or denied on the production of a sick-note, provided by a qualified doctor. Of course, these three categories need not be mutually exclusive. They may exist co-extensively, and may reinforce each other. Since our interest in the phenomenon of medicalization lies in its possible consequences for personal autonomy, our strategy in the following chapter will be to critically assess each of the three accounts in turn in light of the preceding chapters.

One important point to be made about the process known as medicalization is that, if there is such a process, then it must be systematic. There is no doubt that individual members of the medical profession may have a detrimental effect on some of their patient's capacity for autonomy. Doctors are, after all, human beings. They might prescribe a pill that unwittingly injures a patient; they might fail to diagnose a life-threatening disease until it is too late; surgeons have been known to perform operations on the wrong patient. But these are not the systematic restrictions on autonomy that the three medicalization theses seem to imply. After all, there are other occasions when the doctor will diagnose the disease and when the surgeon will perform the correct operation on the correct patient. What we are concerned with in the following chapter is the implied claim that there is some logic underlying the practice of medicine that necessarily impinges upon patients' (and potential patients') capacity to exercise their autonomy.

IV.ii: Medicalization and the Medical Profession

There have undoubtedly been revolutions within the field of medicine. The discovery of the circulation of the blood by William Harvey in 1628; the development of the 'germ' theory of disease-causality following the work of Louis Pasteur in 1864; the discovery of penicillin by Alexander Fleming in 1928 (though penicillin was not employed clinically until 1941) - these are but a few of the many innovations which have revolutionised the practice of medicine. But the medical profession is not self-contained and isolated from society, and medical practices can and do impact on the wider social environment so that revolutions within the profession of medicine might conceivably have revolutionary consequences for society at large. This may be difficult to demonstrate in any definite, quantitative sense. It would, for example, be plausible to assert, but difficult to prove, that the permissive attitude to sexual activity said to be characteristic of the nineteen-sixties, owed something to the introduction of penicillin - an effective cure for what were then the most widespread of the sexually-transmitted diseases. It would, of course, be trite to attribute the sexual revolution solely to the introduction of penicillin, for there are a number of other factors which may also have contributed (the contraceptive pill; the legalisation of abortion; a consciously-articulated desire to overthrow prevailing attitudes and prejudices, to name but three possible candidates). All the same, if the presence of a disease has an effect on how people conduct their lives, then the removal of that disease through preventive or curative measures might itself have some palpable effect on the lives of sufferers. Insofar as the medical profession is the agent of that prevention or cure, then it may be concluded that the medical profession is responsible for creating the possibility of such

change in the lives of sufferers. For example, prior to the appearance of the Human Immuno-deficiency Virus (HIV) and the Acquired Immune Deficiency Syndrome (AIDS), bath-houses were an integral part of the 'fast track' lifestyle of many male homosexuals living in San Francisco³. Had HIV/AIDS not appeared, it is not unreasonable to suppose that the bath-houses would still be an important aspect of San Franciscan 'gay' culture. It is also not unreasonable to suppose that, were a cure for HIV/AIDS to be introduced in the near future, the bath-houses might resume their former role.

One might wish to conclude from this superficial discussion that we already have an account of medicalization. If the medical profession can affect the way people live, indeed, can assist people to live (or not), then the medical profession could be said to exercise a measure of control over the lives of individuals. But it would be illegitimate to infer that simply because developments take place within the field of medicine, then the medical profession - who administer these developments to the public at large - thereby exercise control over the public. At least, this is not the implication of the particular account of medicalization currently under discussion (although it may be implied by Illich's account - see **section ii(a)** below). What we are interested in here is the phenomenon of medicalization said to derive from professional self-interest. That the medical profession is self-interested could be said to have been demonstrated by the profession's insipient conservatism. This has shown itself as much in the recent

3. For an account of the political debate surrounding San Francisco's gay-men's bath-houses in the context of a discussion of autonomy see Patricia Illingworth, AIDS and the Good Society, (London: Routledge, 1990), pp.86-89 for an account in the context of a discussion on autonomy.

objections to Conservative-inspired attempts to alter the nature and structure of the National Health Service (including the doctors' working contract), as it did to Labour-inspired attempts, in 1946-48, to create a National Health Service in the first place. This indicates that the medical profession itself is liable to be influenced - willingly or not - by broader social developments. It could be said, of course, that conservatism is common to most professions in that they exist, in part at least, to defend the interests of their members. But paradoxically, an important part of the profession's defence of its members consists in a defence of that characteristic which has made it one of the most revolutionary of professions. This is its scientific status. The importance of scientific status to the medical profession has been acknowledged by some of the leading figures of the medical establishment⁴. There are several reasons why scientific status might be important to the medical profession.

First, scientific status might be important to the profession when it comes to commanding resources. If a Government wishes to finance the health of its citizens, it will choose those branches of health care which are scientific, over those which are or appear to be unscientific. What makes science ostensibly so important is its methodology. The philosopher of science Sir Karl Popper has suggested that what is characteristic of the scientific method is its attempt to test

4. For example, Sir Douglas Black, (Chief Scientist to the D.H.S.S. from 1973-77 - during which time he chaired the influential committee on Inequalities in Health; President of the Royal College of Physicians, 1977-83; President of the British Medical Association, 1984-85; and recently Emeritus Professor of Medicine at the University of Manchester) in his Rock Carling Fellowship monograph An Anthology of False Antitheses, (Nuffield Provincial Hospitals Trust, 1984), p.17. See also his The Logic of Medicine, (London: Oliver and Boyd, 1968), passim.

hypotheses to destruction. This in turn implies that testability is of paramount importance to the scientific endeavour - if something cannot be tested, it cannot possibly be falsified and cannot therefore claim to be scientific⁵. Testability is important as a criterion for the funding of medicine (and other endeavours - weapons systems, for example) because claims about particular practices, medicines, or pieces of equipment will stand or fall under such scrutiny as a test provides. The testability of a drug, practice or piece of machinery is closely linked to an assessment of the effectiveness of that drug, practice or machine, and effectiveness is an important consideration in deciding where funds ought to be placed. In addition to this, the scientific endeavour is sometimes said to be 'value free'. In other words scientific practices are thought to be objective and therefore morally and politically neutral. Where the political complexion of a government might waver between ideological poles the neutrality of a scientific medicine ought, in theory at least, to protect the profession from the vagaries of political life⁶. So long as the medical profession can maintain its scientific and therefore neutral stance, it can, in theory at least,

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5. Popper cites psychoanalysis as an example of a pseudo-science since it is, or so he claims, a practice for which there exists no possibility of falsification. Marxism, on the other hand, is scientific, but its claims have been invalidated by history. See the essay "Science: Conjectures and Refutations" in Conjectures and Refutations, Fourth Edited: Revised, (London: Routledge and Kegan Paul, 1972), p.37. In the case of Marxism it is possible to turn Popper's argument against itself, for it is unclear that Marx's 'prophecies' (the term is Popper's) have adequately been tested. If Popper accepts the scientific status of Marxism, then he must accept that it is testable. But that a theory is testable does not imply that it has, in fact, been tested. A Marxist might wish to argue that Marx's theories have yet to be falsified.
 6. Peter Conrad and Joseph Schneider, Deviance and Medicalization: From Badness to Sickness, (St. Louis, Missouri: C. V. Mosby & Co., 1980), p.249; see also Sylvia Noble Tesh, Hidden Arguments: Political Ideology and Disease Prevention Policy, (New Brunswick, N.J.: Rutgers University Press, 1988), p.33

continue to command a substantial share of the public purse.

The scientific status of medicine also enables it to exercise some measure of control over which health practices are to be admitted to its ranks, and which are to be excluded. It is partly on the grounds that they are not scientific that many so-called alternative medicines or health practices are not officially recognised by the medical profession⁷. A patient will not usually find a doctor recommending that they visit the local herbalist, or the local acupuncturist, and rarely will a visit to a hypnotist be prescribed. Doctors in the main fight shy of sending their patients to 'outsiders' - that is, to anyone who is not a qualified member of the profession.

The claim to scientific status is also important in another respect. As Ian Kennedy has suggested, for the medical profession, the appellation 'scientific' connotes:

working in the realm of truth and knowledge, light years away from the barber and the bleeder of the past⁸.

The history of the medical profession can be read as an onward and upward march out of the gloom of ignorance, and so away from the

7. Joel Richman points out that attempts to distinguish alternative from orthodox (or 'cosmopolitan') medicine will always run into difficulties. If effectiveness is to be a criterion for inclusion in the canon of 'official' medicines, then some currently unofficial practices would have to be included since, for many of those who utilise them, alternative medicines do in fact work, often after orthodox medicines have failed to do so. Indeed, homeopathy - whose practitioners do not necessarily claim scientific status - has been noticeably successful in treating allergies, and is accepted as complimentary to more mainstream practices. The N.H.S. apparently operates six homeopathic hospitals. Richman, Medicine and Health, (London: Longmann, 1987), pp.209-210. See also Richard Taylor, Medicine Out of Control: The Anatomy of a Malignant Technology, (Melbourne: Sun Books, 1979), p.40

8. Kennedy, op. cit., p.22

superstitions, myths and magic spells that ignorance sometimes entails. The claim to scientific status is also a claim which engenders a distinction between 'primitive' medicines and modern, or scientific medicine, not only primitive in terms of the kinds of practices one might find in the third world, but also some of the so-called 'fringe' practices or alternative medicines practiced in first world societies. The link with science associates the medical profession not only with the search for truth and knowledge, but also with progress⁹.

But the scientific character of the medical profession is open to criticism. According to Popper, testability is of prime importance to the scientific endeavour. But there are both practical and theoretical difficulties with Popper's account of how scientists conduct their work. One important problem with Popper's criterion of demarcation between science and non-science (or pseudo-science) is that scientists test for particular reasons and therefore (usually) look for particular results. It is possible that this blinds them to other, unintended consequences of the process, drug, or machine they are investigating. During the 1940s, for example, high doses of oxygen were administered to immature babies in order to give them a healthy pink complexion. It did, but it also irreversibly blinded many of them. This unintended consequence was not connected with the practice until controlled trials were conducted in 1954¹⁰.

9. The generally utopian attitude to scientific medicine is well-captured in the following quotation from 1944: 'Science has shown, and is showing us, what can be done to make human beings sound in bodily and mental health. By the application of science, we can make ourselves longer-lived, taller, stronger, less prone to disease, anxiety and pain. From half men we can become whole men'. James Mackintosh, The Nation's Health, (London: The Pilot Press, 1944), p.5

10. Richman, op. cit., p.35

A further problem with Popper's account is its inconclusiveness. It is, claims Popper, characteristic of a scientific theory that it can never be confirmed absolutely, only falsified. The best that could be hoped for is that, in the absence of falsifying instances, an hypothesis will be corroborated by further tests, although the possibility of its refutation by some future test will always remain. The task of the scientist is to devise ever more difficult tests for the theory, since the theory that withstands the hardest tests will be the most effective for us now, or at least until a better theory can be found. This, of course, amounts to the survival of the fittest amongst scientific theories. The practical problem that arises is in deciding at what point one is satisfied that enough tests have been conducted for a particular theory (or drug, or practice, or machine) to be declared effective. It has been pointed out that, as a matter of fact, the effectiveness of a particular drug, practice or machine will not always have been established prior to its introduction¹¹. Of course, the introduction of a drug, practice or machine need not be taken as evidence that it is considered to be fully effective, or that all of the effects or defects are fully understood. It would seem to be in keeping with the spirit of Popper's account of science that there should exist a system whereby new drugs are tested for effectiveness before they are made available for use, and are monitored for side-effects after their introduction. It has been pointed out though, that whereas regulatory mechanisms exist with

11. Taylor cites the case of computerised axial tomography (C.A.T.) used for pinpointing malignant tumours. For this, a machine is required which can take multiple X-rays of the body. These, when processed by a computer, produce a detailed and clear picture of the 'soft' parts of the body. Although the machine is astronomically expensive and there exists almost no assessments of its effectiveness, a number of American hospitals have purchased one, and some have purchased several. Taylor, op. cit., p.66-67

respect to drugs, there as yet exists - in the United Kingdom at least - no regulatory mechanism with regard to technological innovation¹². It is possible that the urgency with which some drugs are required might mean their introduction prior to what would count as adequate testing in less urgent times. Indeed, the testing of some drugs amounts in some cases to their introduction, albeit amongst selected groups of volunteers when, for instance, this is necessitated by the unavailability of suitable alternatives. Attempts to find a vaccine for HIV/AIDS have been hampered by the uniqueness of the human immune system. The only suitable alternative to the human subject appears to be the chimpanzee, and there is now a shortage of these animals for experimental purposes - the result of increased demand amongst scientists engaged in a search for an effective vaccine.

Popper's account of the scientific endeavour has also been criticised as to whether or not it is an accurate account of what, in fact, scientists do. It has been suggested by Thomas Kuhn that, far from continually seeking ever more difficult tests for their hypotheses, scientists in fact readily accept as scientific doctrine (or dogma) sets of theories and hypotheses as a starting point for their subsequent research, and that they are far more reluctant to jettison theories in the face of apparently falsifying instances than Popper allows¹³. Kuhn argues that scientists, on joining a scientific community, are inducted or indoctrinated into a set of beliefs and practices - a paradigm - which

12. This is not the case in the U.S. for example, where, since the 1970s, there has existed the United States Office of Technological Assessment. Richman, op. cit., p.35

13. Thomas Kuhn, The Structure of Scientific Revolutions, Second Edition, (Chicago: University of Chicago Press, 1970), pp.10-11 and p.35

at once sets the parameters of their research, shapes the kinds of problems with which they will be concerned, and also shapes the kinds of answers that they will find to those problems. Although it is tempting to see Popper's and Kuhn's respective theories as incompatible, this need not be the case¹⁴. However, Kuhn's theory does (and Popper's does not) indicate the extent to which science, for all its claims to objectivity, may itself be shaped by subjective factors. Kuhn's claim implies that science is not the objective, value-free enterprise it is often claimed to be. Once this is granted, it follows that scientists might be expected to bring their prejudices to bear upon their work¹⁵. What is not clear is that this must result in the medicalization of doctors' patients. Since doctors are themselves embedded in a social context (they are, as a profession, one of Raz's exemplary social forms) they will, at least as individuals, reflect the prevailing mores and attitudes of their own society.

All the same, professional self-interest (with or without the support of scientific kudos) of itself does not seem to do the work that the medicalization thesis appears to require. There are two reasons why this account of medicalization need not unduly affect an individual's personal autonomy. First, an important component of medical practice is directed at alleviating suffering. In a sense then professional self-interest is tied to a concern for the welfare of others (and this is true of all the 'caring professions'). If our previous argument - that ill-health restricts the capacity of persons to exercise their autonomy - is well-founded, then there seems no real reason to conclude that

14. Bryan Magee, Popper, (Glasgow: Fontana, 1973), p.41

15. E. Friedson, Profession of Medicine, A Study of the Sociology of Applied Knowledge, (New York: Dodds, Mead and Co., 1972), pp.253-254

medicalization through professional self-interest necessarily reduces autonomy. If the concern of the medical profession is to restore health to sick individuals, then it should also have the effect of restoring the capacity to exercise autonomy to those individuals, where the illness had either thwarted this capacity, or threatened it.

The second point to be made concerns the way in which medicalization, as professional self-interest, may be said to proceed. Some commentators have suggested that the medical profession is an imperialistic social phenomenon, seeking, through its ability to exclude alternative practices as unscientific, to monopolise the practice of medicine. Medicalization is sometimes said to occur when an activity that has previously been considered to be, say, a moral failing, and hence not the business of the medical profession, is labelled an illness and therefore legitimately becomes the subject of medical intervention¹⁶. Thus, if alcoholism is labelled a disease by the medical profession (as it has been), it may be that the alcoholic is no longer seen as morally culpable, but as someone who has succumbed blamelessly to a disease. The alcoholic may then be accorded treatment formerly denied to him¹⁷. The imperialistic face of medicalization can be said to be revealed in the

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16. Several writers about medicalization make this point. See, for example, Irving K. Zola, "Healthism and Disabling Medicalization" in Ivan Illich et al Disabling Professions, (London: Marion Boyars, 1977), pp.43,53; Taylor, op. cit., p.224; Kennedy, op. cit., p.13; Robert Crawford, "Healthism and the Medicalization of Everyday Life" in International Journal of Health Services, (1980), Vol.10(3), p.368.
17. The process may be also be reversed. In the United States, for example, the medical profession has recently announced that homosexuality is not, in fact, an illness at all. This has the effect of de-medicalizing homosexuals, although the benefits of this are ambiguous since it may also be said to foist responsibility for their sexual preference back onto individual homosexuals. This opens up the possibility of blaming homosexuals for any detrimental consequence of their 'chosen' lifestyle.

following way: if the medical profession does indeed have a legitimate role as the arbiter of disease, then the possibility exists for the medical profession to create a constant and expanding clientele upon which it may practice its art¹⁸. Edwin Chadwick, the great nineteenth-century sanitary reformer, suggested that his proposals for sanitary reform would render the medical profession redundant¹⁹. As we have already seen, William Beveridge, architect of the British welfare state, suggested that as the health of the population improved, so the costs of operating the welfare state would decrease. Both men were in a way suggesting that the medical profession's role in society would ultimately be residual. Medicalization can thus be seen as a process which ensures that this is not, and never will be, the case. But even if this is an accurate description of the medical profession's rationale (and it must be said that the medical profession is often reluctant to 'officially' declare something a disease - witness the current dispute within the profession concerning 'post-viral syndrome') it need not result in a further restriction of personal autonomy. It has been suggested, for example, that medicalization represents not so much a reduction of autonomy in the face of expanding medical practices, as a new division of labour within the social services generally²⁰. If this is the case, then medicalization loses much of its interest for our purposes since we are concerned with how the medical profession might idiosyncratically affect a person's capacity for autonomous behaviour.

18. Taylor, op. cit., p.190

19. R.A. Lewis, Edwin Chadwick and the Public Health Movement, 1832-1854, (London: Longman, Green & Co., 1952), p.77

20. This is argued with regard to paediatrics by Sydney A. Halpern, "Medicalization as Professional Process: Postwar Trends in Pediatrics" in Journal of Health and Social Behaviour, (1990), Vol.31 (March), pp.28-42

One characteristic of the scientific aspect of medicine has been the increasing predominance of technology as an aid to investigation, diagnosis and cure of the sick. But some commentators have suggested that the medical profession has developed a romantic attachment to machinery, and that this has affected the way that doctors, surgeons and so on now approach their work. It is argued that the medical profession prefers technological solutions to the problems of ill-health than less machine- or drug-intensive therapies, and that this is not always to the benefit of the patient²¹. It has been pointed out, for example, that technological advances have almost always been invasive, the body of the individual becoming ever more narrowly the focus of concern and the site of treatment - resulting in an almost exclusive dependence on the medical model - or 'germ theory' - of disease causality, a model for which the explanatory base of ill-health is 'the internal structure of the individual'²². This model is sometimes criticised for ignoring or failing to give adequate significance to environmental sources of ill-health.

One important problem with technological solutions to illness is that they do not always solve the problems they are designed to solve, and often create further problems for the patient. Transplant surgery, for example, can have beneficial effects. Kidneys are transplanted into patients suffering from kidney problems almost as a matter of routine now. But the limited success of kidney transplants has not been generalised to other organs of the body. Even with kidney transplant

21. Ivan Illich, Limits to Medicine. Medical Nemesis: The Expropriation of Health, (Harmondsworth: Penguin Books, 1977), p.97. See also Taylor, op. cit., p.3

22. Richman, op.cit., p.33

surgery, a patient's chances of survival are better if the grafted organ comes from a close relative rather than an anonymous donor. Any form of transplant surgery requires that the recipient's immune system be suppressed to avoid rejection of the implanted organ. This can lead to other complications - infection by opportunistic diseases - and even to an increased risk of cancer²³. But the failure of a particular technology to solve a problem need not result in the medicalization of the individual to whom the technique is applied. Certainly, the patient who undergoes a heart transplant operation is then condemned for the remainder of his or her life to a regime of medication and close surveillance by the medical profession, but this may seem like an acceptable trade-off to patients who might otherwise have died of their illness. In fact, even where a patient requires constant medication, the patient may be made relatively autonomous regarding the administration of that medicine - as is usual practice now with diabetics.

A more convincing account of medicalization would be the tendency for some doctors to prescribe tranquilizers to those patients whom they diagnose as clinically depressed. The effect of this practice is to create a dependency on the part of the patient, overtly on the drug prescribed, but also covertly on the doctor who prescribes it and monitors the patient's condition while the drug is in use. The process at work here is self-perpetuating because the doctor is not treating the cause of the illness (which may be linked to domestic matters, joblessness, social pressure and so on) but rather its effect. The difficulty is, that in prescribing the anti-depressant drugs, the doctor shields the patient against the situation which causes the depression.

23. Taylor, op. cit., pp.150-152

Inured against the cause of his or her depression, the patient is thus no longer capable of judging objectively that the situation, or the patient's own ability to cope with it, has altered for the better. The situation becomes akin to Pascal's wager. Patients who are taking such drugs cannot be sure that if they ceased taking them they would be able to cope with their depression, cannot even be sure that the situation which caused their depression in the first place (assuming that they know what did cause it) has changed for the better. So they keep taking the drug, just in case. In addition to this, of course, the drugs prescribed by the physician might well be addictive. The patient may not easily be able to cease the medication even if they wanted to (witness the difficulty many people experience when they attempt to give up a relatively mild drug like nicotine, obtained through smoking cigarettes). Here we have an example of what Illich has called 'clinical iatrogenesis' - an illness (drug addiction) which is literally doctor-induced.

One reason for the occurrence of situations such as this is that the cause may well be external to the patient, in the patient's domestic or social relationships, for example. Given that this is so, the solution to the depression would seem to be to alter the domestic or social relationships in which the depressed patient is enmeshed. But the doctor's business is with the individual patient and not the patient's domestic or social environment²⁴. Yet rather than admit that the cause of the illness cannot be treated, a doctor will in the main do something rather than nothing. In certain circumstances, there is a tendency on

24. This is a consequence, in part, of the medical profession's adherence to the medical model of disease causality, discussed in Chapter Five, **section iv**, below.

the part of doctors to err on the side of caution when diagnosing particular illnesses, a practice which is not always in the interests of the patient²⁵. But it has also been suggested that a doctor will do something rather than nothing because doing something makes the doctor feel good, and appear to be useful rather than helpless. The point of this is to retain a certain aura of competence in a situation where nothing effective can be done by the doctor²⁶. It might also be the case that doctors are placed under some commercial pressure to prescribe drugs.

Richman cites the example of the medicalization of childbirth. During the nineteen-sixties, special care baby units (SCBU) were set up in many maternity hospitals to cope with the problems arising from both premature babies, and babies born past their full term. British obstetric policy during the early nineteen-seventies aimed at reducing perinatal mortality to the levels achieved at that time by Holland and Sweden (8/1000 deaths). One method employed by obsetricians in pursuit

25. This was demonstrated as long ago as 1934 in a classic experiment on the diagnostic practices of a set of doctors. The experiment involved subjecting a group of 1,000 11-year-old schoolchildren to investigation, upon which 61% were found to have had their tonsils removed. The remaining 39% were examined by a second group of physicians, who selected 45% of these children for tonsillectomy. Those not requiring tonsillectomy were then sent to a third group of physicians for investigation. Of these, 46% were selected for tonsillectomy. Those rejected as not requiring treatment were examined a final time, and again nearly half of their number were diagnosed as requiring tonsillectomy. At the end of the experiment, only 65 children remained who had not been recommended for treatment. American Child Health Association, **Physical Defects: The Pathway to Correction**, (New York, 1934), pp.80-96. Cited in Illich, op. cit., pp.100-101

26. The medical profession throughout its history has engaged in a number of apparently scientific practices designed ostensibly to cure disease (leeching, or 'bleeding' as it was known, is one example). Few of these 'cures' were successful, which is why they are not used today - but this did not stop the medical profession from gaining in status as a result of their employment.

of this aim was to induce contractions - using the stimulant oxytocin - in those mothers who had carried their babies past the 'safe' forty-week term. This gave rise to what has become known as 'the daylight baby syndrome': far from being used solely in the interests of mothers and their babies, induction was used to reduce the number of children born during the night, at weekends, and during holiday periods, thus reducing staff costs. This practice had a number of other effects. Since, for convenience sake, some babies were now being born before term, the incidence of babies suffering from jaundice rose. Furthermore, oxytocin causes powerful uterine contractions which mothers are not always able to control. To relieve the distress caused by this phenomenon, epidural anaesthesia was introduced. This practice deadens the labouring mother from the waist down, making it impossible for her to exercise any control over her contractions. Control of the birth process therefore of necessity passed from the mother to the attendant health professional. In addition to this, any drug administered to the mother during pregnancy passes across the placenta into the baby. A further result of the control of childbirth by the obstetricians was that more babies were born in need of resuscitation. By 1977 the special care baby units set up in the early nineteen-sixties were dealing with three times as many casualties as they were in 1964, only this time they were the casualties of high-technology medicine²⁷.

The importance of technology to the process of medicalization is also illustrated with respect to the diagnostic process - a key weapon in the medical profession's prevention armory. Taylor makes the point that by designating people 'at risk' from a disease, the medical profession

27. Richman, op. cit., p.36

can medicalize even those who are not suffering from any illness²⁸.

Indeed, it has been suggested that 'health' itself is increasingly being defined in terms of illness, or by an absence of illness²⁹. The increasing reliance of the medical profession on a battery of tests and screening programmes rests, according to Richman, on a belief that more tests equals better diagnoses equals better treatment. He goes on to suggest, however, that this is questionable in practice - doctors, it seems, may suffer from an information-overload, missing results, misinterpreting data, or even ignoring information derived from the battery of tests³⁰. Furthermore, it seems that many tests employed by the profession are unnecessary, since the information ultimately derived from them could have been obtained by the practice known as 'history-taking' which simply involves the doctor in interrogating the patient concerning habits and so on³¹. It has also been pointed out that doctors will sometimes order a test which is irrelevant to a particular patient's condition, thus incurring unnecessary expense in terms of time and money³².

28. Taylor, op. cit., p.191

29. Taylor, for example, suggests that health is currently understood 'as a state of continued negative reports for hidden disease', op. cit., p.3. See also Kennedy, op. cit., p.15

30. Richman, op. cit., p.37

31. Richman cites the experience of the United States when a survey, conducted in 1984, showed that of 52 million chest X-rays taken during that year, 30 million yielded information that could have been gathered from history-taking. ibid. Taylor makes a similar point with respect to history-taking, op. cit., pp.69-70

32. Richman, ibid.

IV.iii: Medicalization as a Social Process

Professional self-interest is only one source of medicalization. In this section we consider two accounts of medicalization, each arising from a particular account of the social process, that is, of the nature and dynamic of modern industrial society. The views are those of Vicente Navarro, whose arguments are self-consciously marxist, and Ivan Illich, whose arguments can reasonably be placed on the right of the political spectrum³³. We shall consider Illich first, then Navarro.

(a) Illich: The Expropriation of Health

Illich's argument begins with an account of the nature of western industrial society. As societies develop technologically, there is, he claims, a consequent specialization of knowledge which results in the development of powerful social groupings - the managers and bureaucracies associated with particular technical processes. This process, labelled 'industrialization' or 'professionalization' is said to supercede, or make irrelevant, traditional concepts of class, ownership and property, and therefore purports to replace traditional marxist and socialist critiques of society. Control of the production process has passed, it is claimed, from the owners of capital to the managers and administrators of that process³⁴. If Chadwick, in the nineteenth century, suggested that the health of the population was the province of engineers rather than the medical profession, Illich, in the latter part of the twentieth century suggests that medical professionals, in their reliance on technology and the achievements of science, have in fact become engineers, and that the medical endeavour

33. David Armstrong, An Outline of Sociology as Applied to Medicine, (London: Wright, 1989), p.128

34. Illich et al, Disabling Professions

'is really an engineering endeavour'³⁵.

It is said by Illich to be characteristic of the process of professionalization that a need is created for hierarchy, and for a dependence of the lower ranks on the upper echelons within the hierarchy. In terms of medicine, the lowest rank consists of patients. The industrialization and professionalization of medicine has what Illich describes as a 'social pathogenic' consequence, which results in a dependence on medical agents that tends ultimately 'to decrease the organic and psychological coping ability of ordinary people'³⁶. In other words, to the extent that the medical profession extends its practices into the lives of individuals, to that same extent does the ability of those individuals to cope with illness decrease. The problem becomes not simply one of the monopoly of health services by the medical profession (although this is part of the problem). The real damage is done at a deeper, structural level:

More health damages are caused by the belief of people that they cannot cope with illness without modern medicines than by doctors who foist their ministrations on patients.³⁷

Illich makes autonomy fundamental to health³⁸. The medical profession, in taking upon itself responsibility for the health of a person, also has the inevitable effect of undermining that person's capacity for autonomous behaviour. It should be stressed at this point that the

35. Illich, "Clinical damage, medical monopoly, the expropriation of health: Three dimensions of iatrogenic tort", in Journal of Medical Ethics, (1975), Vol.1(1), p.78

36. Illich, Journal of Medical Ethics, (1975), Vol.1(1), p.77

37. Illich, ibid.

38. Illich states that the 'ability to cope [with pain, sickness and death] autonomously is fundamental to [Man's] health. As he becomes dependent on the management of his intimacy, he renounces his autonomy and his health must decline', op. cit., p.275 (emphasis in original).

position taken by Illich with regard to the relationship between autonomy and health is not equivalent to that articulated in the previous chapter. Our argument there attempted to demonstrate that health can be a condition of autonomy. Illich's claim is that autonomy is a condition of health. But there seems to be no reason to suppose that a person who lacked autonomy - someone, say, who was compelled to perform certain acts under hypnotic suggestion - must necessarily also lack health. Indeed, the acts suggested by the hypnotist might themselves require that the subject be in good health (for example, he or she might be required by the hypnotist to run five miles). It may well be true that, under certain circumstances, reducing a person's autonomy might result in a worsening of their health. Shutting a person in an overcrowded prison and feeding them a diet lacking in nutrition will bring about a deterioration in health for that prisoner. But restoring autonomy to that prisoner might not restore her health - she might have decided to embark on a hunger-strike. For Illich, to be autonomous is to be healthy, but even the most autonomous of people may develop any number of diseases, from relatively trivial ailments such as a sore-throat, to life-threatening diseases such as cancer. It is not Illich's account of autonomy that is suspect, so much as his implied account of health.

As a solution to the problem of medicalization, Illich proposes two broad strategies. The first of these consists of what might be called the dis-establishment of the medical profession. The state-supported monopoly of health care by the profession should be broken, in order that the individual may choose where, when, and what kind of medical care best suits him or her. This echoes the proposals made by Adam Smith

concerning the monopolistic status of the medical profession during the eighteenth century³⁹. Like Smith, Illich is effectively arguing for the introduction of a free market in health care. The second strategy would necessitate that individual, rather than collective, responsibility for health should be maximised. (Not surprisingly, Illich sees the British N.H.S. as a regressive institution, increasing dependence upon external health care). There is, it seems, a moral dimension to Illich's argument. Insofar as individuals do develop their ability to cope with their own health and ill-health, they will become 'better' individuals, more autonomous. But as we saw in Chapter Two, it is a mistake to equate autonomy with goodness, since the autonomous person might choose a life of wickedness.

The question we need to address, however, is how Illich's account of medicalization might actually be said to work. Here, the crucial concept is 'expertise'. Since the medical professionals with whom the sick individual comes into contact are experts in dealing with sickness, the individual (who is not an expert) surrenders him- or herself to the doctor, surgeon, or whatever. That is to say, that the individual relinquishes control over the choices he or she makes, or will make, whilst in the care of the medical profession. It is the status of this act of relinquishing control that is of crucial importance for Illich's argument. It is fairly common, in the field of medical ethics, to come across the argument that the relationship between patient and doctor is essentially contractual. This implies that there is an equality between

39. Jeffrey Lionel Berlant, Profession and Monopoly: A Study of Medicine in the United States and Great Britain, (Berkeley, L.A.: University of California Press, 1975), pp.152-153

doctor and patient such that, in return for confidentiality on the part of the doctor, the patient will be completely honest about his or her symptoms. The doctor's implicit offer of confidentiality is 'an enticement to sincerity' on the part of the patient⁴⁰. But even if one accepts that the doctor/patient relationship is contractual, it is still possible to cast doubt on the claim that the consultative situation is one of equality. If a contract does exist, then it is unspoken, or tacit, and this means that its terms are unspecified. It is likely then to be open to interpretation - or misinterpretation - by either party. In this the patient may be disadvantaged in that he or she is not in control of the consultation. It is, more often than not, the doctor who interrogates the patient, who knows or is likely to know what is wrong with the patient, and who knows or is likely to know what to do about the patient's illness. Even the language that doctors use sets them apart from their patients⁴¹. The position of authority which they occupy would reinforce the patient's role as 'junior partner' in the 'contractual', consultative, situation. But it is also true that the

40. Michael H. Kottow, "Medical Confidentiality: an intransigent and absolute obligation" in Journal of Medical Ethics (1986), Vol.12, pp.117-122. The principle of confidentiality is enshrined in both the Hippocratic Oath (dating from the 5th century B.C.) and in its modern-day equivalent, the World Medical Association's International Code of Medical Ethics, (Geneva, 1983) in which confidentiality is designated an 'absolute' principle, binding even after the patient's death. Cited in Melanie Phillips and John Dawson, Doctors' Dilemmas: Medical Ethics and Contemporary Science, (Brighton: The Harvester Press, 1985), p.207. In practice, however, confidentiality may not be absolute - a doctor may be required to pass confidential information about a patient to other medical professionals. The British Medical Association's guide to medical ethics - Philosophy and Practice of Medical Ethics, (London: British Medical Association, 1988) - lists seven specific instances in which a doctor might pass confidential information to an outside source, including when the patient consents to this, or when it is in the interests of either the patient or society to do so, or when the law requires it(p.21). See also H.E. Emson, "Confidentiality: a modified value" in Journal of Medical Ethics, (1988), Vol.14, pp.87-90

41. Illich, op. cit., pp.174-175

patient might already be in a vulnerable situation with regard to the doctor because, after all, the patient may be ill. If the patient values his or her health then - confidentiality or not - he or she will have little choice about what is revealed to the doctor and what is not.

The question is whether or not this situation leads to medicalization and a diminution of the patient's autonomy? We have already seen that illness of itself may reduce a person's autonomy. In such cases, a visit to the doctor might well result in a restoration of autonomy. If this is accepted, then Illich's position must be untenable since it cannot be the case that consulting a doctor both restores and eliminates a person's capacity for autonomy. It has also been pointed out that in many cases patients, when consulting doctor, will be quite prepared to surrender their autonomy for the sake of their health⁴². A person may be quite willing to place his- or herself in the hands of a doctor, given that that person does not know at all what the cause of his or her illness might be, or what to do about it. There is no reason to suppose that the decision to visit one's doctor cannot itself be an autonomous decision.

For Illich, though, such a decision would in effect be playing into the hands of the medical profession. But what might the alternatives be? If, in suggesting that we take control of our own bodies in the name of autonomy, Illich is suggesting that we avoid doctors and resort to curing ourselves, then he is asking too much. Suppose that, without the assistance of my doctor, I am nevertheless able to diagnose myself as

42. Onora O'Neill, "Paternalism and Partial Autonomy" in Journal of Medical Ethics, (1984), Volume 10, pp.173-178

suffering from cancer. Suppose too that I recognise that the tumour which I have discovered is operable. Would Illich then insist that, in order to retain my autonomy, I should steer well clear of surgeons? In rare cases it may be true that I could successfully operate on myself. In other cases I may be able to remain conscious throughout the operation so that I can direct the operation. But most cases involving operable tumours will require that the sufferer be anaesthetised completely during the course of the operation. Obviously one cannot anaesthetise oneself and retain control of the proceedings.

If we avoid contact with the medical profession for fear of losing our autonomy, then we would need to enhance our knowledge of our own body so that when we are ill, we will know best what to do. But at this point Illich must also make clear what exactly it is that he is objecting to. Is it the medical profession itself, or the body of knowledge which that profession possesses? If it is the latter, then in order to retain our autonomy the resort to manuals and instruction books published by and for the medical profession would seem to be ruled out of bounds. Broadly speaking, we would then have two options left. Firstly, we might turn to an alternative body of knowledge, such as folk-medicine or acupuncture. But if, in the case of the medical profession proper, our autonomy is curtailed when we resort to its corresponding body of knowledge, it must be the case that resort to any other body of knowledge will similarly curtail our autonomy. Only through the second resort - trial-and-error - would we retain our autonomy on Illich's terms. Not only would this be time-consuming and possibly dangerous, it would also be regressive, in the sense that each one of us would have to make the same mistakes as everyone else in order to learn about our bodies and how to look after

them. If this Illich's position, then he is open to the same criticisms on this last point that were levelled at Wolff in the previous chapter. Paradoxically, returning to basics in order to avoid medicalization might itself seriously restrict our capacity for autonomy because we would have little time to pursue other options considered to be worthwhile.

One of Illich's most trenchant critics is Vicente Navarro. Before setting out his criticisms of Illich, we shall give a brief account of his own position. Navarro is a self-professed marxist, and as such (bearing in mind the discussion of the liberal and marxist traditions in Chapter Three, **section i**) is not central to our concern with the relationship between medicalization and autonomy. We include him here, however, to balance our discussion of Illich.

(b) Navarro: Medicine Under Capitalism

In the opening section of this chapter we stated that the scientific character of the medical profession gave it the appearance of political neutrality. The claim was that since science is an objective, value-free enterprise, it is therefore free from the taint of political ideology. Navarro disputes this claim from both a methodological and from a practical point of view. Methodologically, Navarro claims that to see the medical profession (indeed any social grouping) as somehow autonomous, distinct from the rest of society, amounts to a form of methodological individualism. Any study which does not recognise this will give only a distorted view of the nature of the profession it seeks to understand. Society, for Navarro, is a whole with emergent properties that cannot be explained by studying isolated parts. These parts are

inter-related, and must be understood in their relations to each other. An understanding of the medical profession, how it operates and why it operates in the manner that it does, cannot be obtained without first understanding the dynamics of the society in which the medical profession and the health system is embedded⁴³. In Navarro's view, writing as he does from a self-consciously marxist perspective, the medical profession is linked to, and reflects in microcosm, the prevailing class structure of the society of which it is part⁴⁴. The medical profession not only reproduces the characteristic class-structure of the society of which it is part, but it also reproduces the prevailing ideology. In a capitalist society, this prevailing ideology is liberal individualism, and this is reflected in the field of medicine by the adherence of the profession to the individually-focussed medical model of disease causality⁴⁵. Navarro argues that it is in the interests of capital that the medical model is prevalent, since it diverts attention away from the economic and social causes of ill-health, and makes the individual responsible for his or her own health⁴⁶. It is also for this reason that the state supports the medical profession's exclusion of potentially destabilising (because they are holistic) alternative medicines. Medicalization for Navarro amounts to a form of alienation:

The expropriation of political power from the citizenry that takes place in the political process, and the absence of control over the product and nature of work that workers face in the process of production, are accompanied by the expropriation of control from the patient over the nature and

43. Vicente Navarro, Medicine Under Capitalism, (London: Croom Helm, 1976), p.vii; Crisis, Health, and Medicine, (London: Tavistock, 1986), p.2.

44. Navarro, Medicine Under Capitalism, p.206

45. Navarro, op. cit., p.206

46. Navarro, op. cit., p.207

definition of health in the medical sector.⁴⁷

Medicine serves a legitimising function for the capitalist system, to the extent that citizens accept that their health problems can be solved by medical intervention and behavioural change, rather than political action⁴⁸. In this context, the major preventive strategy is health education, since it reinforces the contention that individuals are or can be responsible for their own health and illness. It is in this context that everyday life, through a focus on life-styles and individual behaviour, has been medicalized⁴⁹.

Navarro's critique of Illich focusses on the claim made by the latter that the medical profession creates a need in individuals to consume health care, and associated products such as drugs. Illich's claim suffers from being too abstract, or theoretical. The process of industrialization, as Illich sets it out, appears to be a universal phenomenon. Medicalization is common to all industrialized societies - capitalist or communist - and will occur in any developing society as it industrializes (the 'convergence theory'). Thus Illich, according to Navarro, ignores the specific social and historical factors shaping the variety of medical systems in existence the world over. It has to be said that in focussing on class struggle as the dynamic of change, Navarro could be accused of much the same sort of universalisation he accuses Illich of. Navarro assumes that, although not all societies on earth are capitalist, all those that are share a set of unified characteristics. Thus the 'western' system of medicine is characterised by growth and effectiveness, and these characteristics result from a

47. Navarro, op. cit., p.208

48. Navarro, Crisis, Health, and Medicine, p.29, 40-41

49. Navarro, op. cit., p.36

tension between the needs created by the process of capital accumulation, and the demands expressed by the working population. In other words, by the class struggle.

The result is that Navarro sees the medical profession as an instrument of socialization. The capitalist economic system itself has a set of basic requirements which are necessary for its survival. These include the creation of wants; the existence of a market (a passive set of consumers); and the replication of a 'consumer ideology' where a person is not judged by what they do, but by what they have or consume. Whereas for Illich, the solution to the problem of medicalization is to de-professionalize the medical profession, Navarro implies that such a solution will leave the real cause of the problem untouched and intact. For Navarro, only a complex reorganisation of society will de-medicalize the population, involving the transfer of power from the middle-class agents of capitalism to the working class.

Obviously, criticism of Navarro's position must ultimately take the form of a critique of his marxist assumptions. We have already suggested that capitalism is assumed by Navarro to be an homogeneous entity. This is questionable⁵⁰. Navarro also fails to discuss the more recent developments within the western system of medicine; the development of the service sector and the rise of the 'new middle class' - indeed whether or not it makes sense to talk of class in the traditional

50. Bryan S. Turner, for example, suggests that one distinction that may be made is between 'early' and 'late' capitalism. Medical Power and Social Knowledge, (London: Sage, 1987), pp.176-180

marxist sense at all⁵¹ - and he does not discuss the significance for individuals, capitalism, or the medical profession itself of the privatization of key medical functions⁵². Another important lacuna in Navarro's writing is an account of the rise of 'alternative' medicines, and where this fits into the class-based account. It has been noted that the popularity of alternative medicine is almost exclusively a middle-class phenomenon⁵³. If so, this calls into question the critical potential of these practices, unless Navarro intends the middle-class to usurp the revolutionary role traditionally assigned by marxists to the working class. Indeed, there seems to be good grounds for thinking that the so-called alternative medicines may themselves be a product of an economic system that, on Navarro's own analysis, both creates and satisfies demands. It has also been suggested that, at least with regard to the United Kingdom, the policies of the incumbent Conservative Government designed where possible to reduce public spending - including spending on health care - have the effect of creating a situation favourable to the 'disorganised' sector of private health care, i.e. the alternative medicines⁵⁴. Insofar as Navarro's account of the medical profession is based on an analysis of the class structure of a society, then his account of medicalization stands or falls with that account.

51. This problem is discussed, for example, by Andre Gorz, The Critique of Economic Reason, Translated by Gillian Handyside and Chris Turner, (London: Verso, 1989), pp.91-103

52. Turner, op. cit., pp.180-183

53. Richman, op. cit., p.

54. Richman, op. cit., p.220. As Richman also points out, it also has the effect of making the Labour Party the defender of the status quo and all that this entails concerning medical hegemony and medicalization, to the extent that it defends the National Health Service.

IV.iv:. Medicine and Social Control

It is sometimes suggested that the purpose of medicalization is to effect some measure of control over the population, although it is not always clear on whose behalf such control is being exercised. It is possible, for example, to read Navarro in this way, where control is effected through the production, by the capitalist economic system, of certain health demands which the medical profession and its allies then caters to. Drugs are a good example of this process, for they are not only geared to the restoration (or maintenance) of health, but are also an extremely profitable enterprise for their producers⁵⁵. Some see the medical profession as a weapon of social control in the hands of the state where, in return for its services, the state rewards the profession by supporting its practices with the force of law⁵⁶. Others see the medical profession as a potential replacement for the 'traditional' institutions of social control - the church and the legislature - as the influence of these wanes⁵⁷. One of the most influential statements of the thesis that medicine is an instrument of social control is that developed by Talcott Parsons, and it is to his account that we now turn.

In order to understand Parsons' account of how the medical profession facilitates social control, we need first of all to say something about

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55. For example, a worldwide potential health catastrophe such as HIV/AIDS presents not only a challenge to scientists to find a cure, but also provides the pharmaceutical companies with the 'greatest new pharmaceutical market in history'. Duncan Campbell, "The amazing AIDS scam" in New Statesman & Society, 24/06/1988, p.10
56. Bryan S. Turner, The Body and Society, (Oxford: Basil Blackwell, 1984), p.213
57. Irving Kenneth Zola, "Medicine as an Institution of Social Control" in Sociological Review, (1972), Vol.20, pp.487-504; "In the Name of Health and Illness: On Some Socio-Political Consequences of Medical Influence" in Social Science and Medicine, (1975), Vol.9, pp.83-87

his general theory of social action. In order to understand human action, Parsons contends that it is necessary first of all to understand the social system with which one is dealing, since it is this system that provides a normative structure to human inter-action. At the risk of drastically over-simplifying Parson's complex work, we may say that individual human action is to be understood as role-oriented, where the role (or roles) that an individual occupies largely explain that individual's action. Social order is maintained by individuals successfully occupying the roles allotted to them, and from which they derive their various duties and obligations to each other. Leaving aside the problem of who or what does the allotting (and the related problem of how, if one's actions are determined by one's social roles, one can ever change one's roles) we can see from this that society consists, for Parsons, in an equilibrium constructed on the ground of role-occupation. Those who do not fulfil their roles, or fulfil them incorrectly, are disruptive to this equilibrium, and hence to social order. Thus they are labelled 'deviants'⁵⁸. Parsons describes society as a sort of steady-state mechanism, an organic phenomenon which is held in equilibrium by the network of roles that characterise it, and the reciprocal duties and responsibilities attendant on those roles. His account of society is ultimately static. There is, for example, no explanation as to how a society might develop, no account of how change might occur within the social system. Change, almost by definition, is instability, and anything that threatens the stability or status quo of society is to be discouraged, or managed. Even values are social things, generated - apparently spontaneously - by the social structure. Amongst other

58. Parsons' argument was initially set out in The Structure of Social Action, (N.Y.: The Free Press, 1937) and was later developed in The Social System, (London: Routledge and Kegan Paul, 1951).

things, it is not clear how one is to view political protest. One may, for example, view political protest in a straightforwardly analytical way as deviancy, since in criticising society it potentially destabilises it. The people of Romania who overthrew Ceaucescu were clearly social deviants in this sense. What is not addressed, and what it is not possible to address from the point of view of the Parsonian social scientist, is whether or not they were right, for that is a matter internal to the social system. Moreover, if values do originate from within the social structure, Parsons cannot adequately explain the existence of conflicting values within a particular society - why, for example, some sections of a population think homosexuality immoral while others do not.

In the field of medical sociology, Parsons' main contribution was to postulate the idea of 'the sick role'⁵⁹. If an illness prevents a person from fulfilling his or her allotted role (or roles) then the person who is ill is potentially deviant, and is therefore potentially a threat to the social order. The threat to social stability is overcome within the terms of Parsons' system by the concept of 'the sick role'. Since the functioning of society depends on the successful occupation of roles, social order will be maintained if the 'deviant' (i.e. sick person) successfully adopts the sick role. The role of the medical profession is

59. The concept of 'the sick role' was developed in "Definitions of Health and Illness in Light of American Values and Social Structure" in E. Gartly Jaco (Ed.), Patients, Physicians and Illness, Third Edition, (N.Y.: The Free Press, 1979), pp.120-144. It has been critically assessed by S. Levine and M. A. Kozloff, "The Sick Role: Assessment and Overview", in The Annual Review of Sociology, (1978), Vol.4: pp.317-343; Raymond Illsley, Professional or Public Health? Sociology in Health and Medicine, (London: The Rock Carling Fellowship/The Nuffield Provincial Hospitals Trust, 1980), pp.73-77; and Bryan S. Turner, Medical Power and Social Knowledge, pp.39-41.

to legitimise the patient's adoption of the sick role - if it did not have this legitimizing function any shirker could claim to be sick in order to avoid his or her responsibilities. The only way to escape from one's role without disrupting the social order is to slip into another role (providing, of course, that it is not the role of shirker).

But the sick role brings with it a new set of responsibilities, amongst which are that patients will seek the assistance of the medical profession should they fall ill, and that they will do as their doctor tells them to do in order to get back into their proper role as quickly as possible. For their part, doctors must be neutral and detached, as are scientists. Since they have privileged access to the bodies of their patients, for example, all eroticism must be removed from the medical encounter. Doctors must have 'technical-specificity' which seems to mean that they must be experts in their field. Doctors must also be 'collectively orientated', which means that they must not become profit-orientated businessmen. Parsons suggests that they are in this respect something of a maverick profession (but not deviant) in capitalist society, which is geared toward the profit-motive. Insofar as Parsons has a theory of medicalization it consists in the adoption of the sick role by the patient. Medicalization, therefore, protects society from disruption by sanctioning certain behaviours and so marking others out as properly deviant. It is through its legitimization of sickness that the medical profession acts as an instrument of social control.

Parsons' view of medicalization has the effect of rendering 'deviant' behaviour legitimate. This is achieved by declaring a disruptive state an 'illness'. One potentially positive effect of legitimising 'deviant'

behaviour is to obviate the stigma that sometimes attends particular 'illnesses'. If alcoholism can be defined as an 'illness' amenable to cure or treatment by the medical profession, then alcoholics may be placed beyond the reach of moral disapprobation⁶⁰. Medicalization, in this respect, has been linked to a wider humanitarian trend⁶¹. But it has also been argued that there is a negative side to this process for it may be that removing blame also removes responsibility from an individual, and therefore robs that individual of his or her dignity⁶². Thus one effect of medicalization is to divorce responsibility from social action, creating a two-tier society comprising on the one hand of morally responsible people and on the other a set of amoral sick people⁶³. It might also have the effect of undermining the very idea of morality, since we end up with no concept of 'evil', only of 'sickness' or 'deviancy'⁶⁴.

But it is not only the notion of moral responsibility that is undermined by Parsons' account of action, for it also undermines the notion of personal autonomy that we developed in Chapter Two. This is not a problem of medicalization as such, for medicalization is but a facet of the way society generally functions within Parsons' system. The question

60. Conrad and Schneider, op. cit., p.247

61. Conrad and Schneider, op. cit., p.246

62. R. M. Veatch, "The Medical Model: Its Nature and Problems", in A. L. Caplan; H. T. Engelhardt; and J. J. McCartney (Eds.), Concepts of Health and Disease: Interdisciplinary Perspectives, (Massachusetts: Addison-Wesley Publishing, 1981), p.531. Veatch's use of the term 'medical model' is derived from Parsons, so that he means to refer, not to the model of disease causality (discussed in Chapter Five, **section iv**) that is usually linked with this term, but instead the Parsonian model of social structure as it is applied to medicine. This explains why Veatch talks of the medical model as denying individual responsibility for illness, whereas the medical model as it is generally understood suggests the opposite.

63. Conrad and Schneider, op. cit., pp.248-249

64. Conrad and Schneider, op. cit., p.255; Kennedy, op. cit., p.6.

is whether or not there can be autonomous action within a system where actions are said to be determined by the roles we occupy? In a determined universe such as Parsons' seems to be, it must be the case that, if the roles we occupy determine the way we act, and the roles an individual occupies are themselves determined by the social structure, then deviancy, if and when it occurs, must also be determined by that same structure. If this is not the case, then some explanation is necessary as to how it is that some (i.e. deviant) actions manage to avoid determination while others do not. It also looks very much as though the only free actions (by which is meant actions not determined by the social structure) are those perpetrated by social deviants. If there can be free actions, there is no reason to suppose that they would of necessity manifest themselves in deviant behaviour. After all, an autonomous person might choose a life of dull conformity over a life of romantic rebellion but they would be no less autonomous for that, just less interesting.

Conclusion

If the medicalization thesis is that the medical profession, through its various activities, systematically reduces the autonomy of those who come within its ambit, then none of the theories that we have so far considered appears successfully to achieve this. If, as we argued in the previous chapter, health is important to the exercise of autonomy, then it seems that the medical profession must at least some of the time have a positive effect upon its clients' autonomy. We do not deny that, on occasion, representatives of the medical profession might have a detrimental effect upon a person's capacity for autonomy, but this is

unlikely to fulfil the medicalization thesis' requirement that it be a systematic effect of medical intervention.

In the next chapter we examine a particular aspect of health policy from the perspective of our account of personal autonomy. Through an examination of the assumptions underlying the British-government sponsored **Prevention and Health** campaign we consider the implications for health policy of adopting the account of autonomy developed in the first three chapters of this thesis. In particular we shall be concerned to examine the problems for our account of autonomy generated by the medical model of disease-causality which appears to have underpinned the proposals made in the documents published under the **Prevention and Health** rubric. We also (in **section v**) focus on the related issue of responsibility for health that arises on the ground of this model of disease-causality.

**Chapter V: Autonomy and Preventive
Health-Care Policy**

Introduction

In the previous chapter we examined the phenomenon known as 'medicalization' the importance of which to our overall argument lay in its purported ability to systematically undermine the autonomy of individuals as patients under the auspices of the medical profession. The central difficulty of the thesis, as we indicated in the previous chapter, is that the medical profession appears to have the ability to restore autonomy to their patients. That this is so must be understood in the light of our previous argument concerning the relationship between personal autonomy and health. If health is indeed an important condition of personal autonomy (where this is understood to comprise not only of the capacity to choose from amongst a set of options, but also to implement one's choice) then the medical profession, at least to the extent that it successfully restores health to its patients, can also be said to enhance the autonomy of those patients. It must be reiterated that we do not deny that the medical profession, or certain of its members, can have a detrimental effect upon the autonomy of some of its clients - doctors have been known to fail to diagnose, or to mis-diagnose illnesses on occasion, sometimes with disastrous consequences for the patient. But such instances do not bear out the general argument, characteristic of the medicalization thesis, that the medical profession systematically undermines autonomy.

However, there may be an important sense in which autonomy might be undermined through a restriction of choice. We have already noted, with Joseph Raz, that the autonomous person must have a range of choices from which to assemble his or her life. A person who has no choice, or only one choice to make, will find their capacity for autonomy restricted.

This in part accounts for the importance of health to autonomy, since ill-health may restrict the number of choices a person might have. We noted in the first part of the preceding chapter that the medical profession, by virtue of its scientific status, excludes a number of health practices from its ranks, effectively consigning such practices (the 'alternative medicines') to the private sector. The effect of this is to restrict the health-care options available to those people who, for whatever reason, cannot afford to pay for private medical care. In a sense then, those people who cannot afford private medical care and whose illness does affect their ability to exercise their capacity for autonomy will find their autonomy undermined twice over - the first time through their illness, and the second time through the restriction placed upon them by the combination of financial circumstances and the exclusive practices of the established medical profession. Of course, those people who can afford to and choose to utilise the private medical sector will be constrained, under the present system of health-care funding in the United Kingdom, to pay for services they may no longer require (assuming that private medicine, in whatever form it may take, can cover all the contingencies of state-funded, 'established' medicine, which is, at present, doubtful). A government concerned to maximise the autonomy of its citizens may choose either to bring all health-care practices under the umbrella of public funding, so that those who cannot afford independently to seek alternatives to 'established' medicine are given the opportunity to do so, or it might follow Illich's advice and 'dis-establish' the medical profession altogether, withdrawing direct funding from health-care in favour of, for example, a system of incentives to individuals to provide health insurance for themselves. We

shall not argue the merits or demerits of these alternative routes to enhancing personal autonomy here.

Instead, our concern in the present chapter will be to consider the relevance to personal autonomy of a particular aspect of health policy - preventive health-care. There is one reason why a concern with this particular area of health policy should be interesting to us, and this is the claim that preventive health-care pre-empts the process of medicalization¹. This claim, of course, assumes that there is at least some substance to the medicalization thesis (in one of its forms), and we saw, in the previous chapter that doubts exist concerning this. Even so, within the terms of some theories of medicalization, the status of prevention is itself suspect. According to some versions of the medicalization thesis, it is always possible that the medical profession might bring some hitherto non-medical behaviour within its sphere of influence by turning it into an object of medical interest. For example, we have already noted that the term 'health' lends itself to a variety of interpretations. If the business of the medical profession is to procure the health of its clients (i.e. patients), and health covers a wide range of factors, activities and capacities, then those factors, activities and capacities might conceivably become the business of the medical profession. We have only to recall the World Health Organisation's definition of 'health' as being 'a complete state of physical, mental and social well-being, not merely the absence of disease or infirmity'. Given such a wide-ranging definition of health there would appear to be few, if any aspects of life which may not be

1. Peter Conrad and Joseph Schneider, Deviance and Medicalization: From Badness to Sickness, (St. Louis, Missouri: C.V. Mosby & Co., 1980), p.255

medicalized. Paradoxically, it seems, preventive health strategies may result in an increase in the surveillance of the population through the creation of categories of 'risk', where, for example, sections of the population are singled out as candidates for screening programmes. The result is that even when individuals are not ill, they may, according to this argument, still be the object of medical attention. In Crawford's phrase, what occurs is the 'medicalization of everyday life'². This may also be said to have the odd effect of creating, in Parsonian terms, a 'potentially-sick role' such that, even when an individual is not yet ill, he or she might be said to have a socially-derived responsibility to participate in preventive programmes³. We return to the issue of responsibility for health below, in **section v** where we also relate the discussion of prevention to our previous discussion of medicalization.

Our central concern in this chapter, however, is to consider what implications might follow from adopting our account of personal autonomy as an organizing principle of social policy. Given our argument in the first three chapters it follows that of particular interest to us here will be the kinds of persons that health policy assumes there to be. Health policy, of course, is a large and diffuse area of concern. To attempt an examination of health policy as such would clearly be impossible in a work of this size. In order, therefore, to facilitate

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2. Robert Crawford, "Healthism and the Medicalization of Everyday Life" in International Journal of Health Services, (1980), Vol.10(3), p.380. See also Ivan Illich, Limits to Medicine. Medical Nemesis: The Expropriation of Health, (Harmondsworth: Penguin Books, 1977), pp.96-104
 3. Crawford, op. cit., p.379. It is interesting to note in this context that the British government has recently advocated a programme of 'regular and frequent health checks' by General Practitioners for elderly people and children. Department of Health, Promoting Better Health, (London: HMSO, 1987, Cm.249), para.1.15, p.4

our discussion, we concentrate our attention upon one particular area of health policy - prevention. But even this particular area is itself too cumbersome to deal with adequately in a work of this size. In order that we might have a manageable discussion, we concentrate on one specific set of policies within the field of prevention. We shall concentrate our attention on the **Prevention and Health** campaign, launched under the auspices of the British Government's Department of Health and Social Security in 1976. The interest of this campaign lies partly in its self-conscious raising of the issue of prevention within the context of what was perceived to be a cure-oriented health service; partly in its focus on the individual as opposed to the medical professional as the agent of health; and partly in the fact that the series of documents issued at the time both invoked a tradition of preventive health-care stretching back to the great public health reforms of the nineteenth-century. It is also true that the documents published in the **Prevention and Health** series represent the British Government's last or latest word to date on lifestyle or behaviour-related illness. The publications, spanning a period of six years, have not been revised since they first appeared over a decade ago⁴.

Some commentators have argued that, following the creation of a national health service in 1948, a curative approach has predominated, despite the aims set out in both the National Health Service Act (1946), and the

4. Publications by the Department of Health and Social Services (D.H.S.S.) under the **Prevention and Health** rubric were **Prevention and Health: Everybody's Business** (1976); **Reducing the Risk: Safer Childbirth and Pregnancy** (1977); the White Paper **Prevention and Health** (Cmd.7047, 1977); **Eating for Health** (1978); **Avoiding Heart Attacks** (1981); and **Drinking Sensibly** (1981). The Health and Safety Commission also published **Occupational Health Services: The Way Ahead** (1977).

White Paper that preceded it (1944)⁵. One important reason why this claim is made is that the National Health Service, in its present form, is 'demand led', as doctors themselves recognise⁶. It is clear that most individuals have recourse to the medical profession when they are, or suspect themselves to be, ill. This suggests that, in the main, the medical profession is not called upon to prevent illness, but to cure or at least to manage an illness that has already established itself in the body, or person of the patient. This suggestion itself depends upon a commonplace distinction between preventive medicine or medical care and curative medicine. The force of this distinction itself derives partly from the extent, through time, of its usage - it can certainly be traced back to 1878, and probably beyond⁷ - and partly from the apparent simplicity of the dichotomy. On investigation, however, the distinction between curative and preventive medicine is revealed as more complex than it seems. It has been pointed out that 'prevention' is often invoked as a rhetorical device by politicians (of all political hues), by medical professionals, and by 'consumers' of medical services alike⁸. This tends to give prevention a politically neutral veneer, with preventive policies cutting across political barriers (rather like environmental issues). Others suggest that prevention has become something of a 'buzzword' - abused almost as often as it is used⁹. For this reason, our concern will be as much with the limitations of the

5. Judith Allsop, Health Policy and the National Health Service, (London: Longman, 1984), p.30

6. Dr. Peter Toon, "Symposium on Prevention", The Practitioner, December 1987, Vol.231, p.1585

7. William Stokes, State Medicine: A Discourse, Delivered Before the University of Dublin, 6/4/1872, (Dublin: John Falconer, 1872)

8. David Billis, "At Risk of Prevention", Journal of Social Policy, (1981), Vol.10(3), p.367; Allsop, op. cit., p.173

9. Lenn E. Goodman and Madeleine J. Goodman, "Prevention - How Misuse of a Concept Undercuts Its Worth". Hastings Centre Report, 1986, pp.26-38

concept and its attendant policies as with its advantages. Preventive health-care policies reflect a number of underlying assumptions and theories concerning the aetiology of disease and the appropriate methods of dealing with those diseases, as well as certain political or ideological views about where responsibility for preventive policies ought to be located. Having developed an account of personal autonomy in the first half of this thesis, we shall want to assess the assumptions concerning those persons and their abilities made in the **Prevention and Health** documents. This will not spell out the kinds of policies that might be entailed by employing our account of personal autonomy as an organising principle. It will, however, allow us at least to criticise a set of policies by pointing up the inadequacies of the assumptions upon which they rest. Are aims, then, are negative rather than positive.

V.i: The Concept of Prevention

On the face of it, prevention is a simple concept. It has been remarked that, at least with respect to the physical world, 'to prevent' means 'to stop'¹⁰. But placed in the context of social policy, this apparently straightforward statement begs a number of questions, for we might want to know what it is that is to be prevented or stopped. We might also want to know how a situation is to be prevented or stopped, and by whom. Finally, we might want to know why a situation is to be prevented or stopped. Billis claims that, with regard to the physical world, the concept of prevention can be illustrated in the following way:

$$(A \rightarrow B) \rightarrow P$$

The variables in this proposition refer, respectively, to a causal factor (A); a physical factor (B); and a problem-state (P). The proposition is intended to bring out the relational character of the variables - the causal factor acts on the physical factor to produce the problem-state. Since these are variables, they may be filled out in many different ways. Examples of causal factors given by Billis include nails, a deluge, frost and a match. Acting on relevant physical factors - a tyre, land, a water-pipe, and paper - they may give rise to various problem-states. In these cases the problem-states would be, respectively, a puncture, a flood, a cracked pipe, and a forest-fire¹¹. These are fairly straightforward examples of causal relationships. All the same, we can immediately point to some difficulties with the idea of prevention. Let us begin with the notion of the problem-state.

10. Billis, op. cit., p.369

11. Billis, ibid.

What is not immediately clear from the four examples used by Billis, is that they are, of necessity, problem-states. This is partly because they are abstract examples. Given a context, each of these examples could conceivably be redescribed, if not perhaps to be positively beneficial, then at least so as not to present a problem. To take just one of the examples: that of the punctured tyre. A puncture that prevented a politician from driving his car away one morning, a politician who failed to realise that a terrorist group had attached an explosive device to the bottom of his car, might seem inconvenient to him (or her) at the time, but would surely be thought beneficial in the long run. Of course, this would be partly a function of perspective. For the terrorist group the problem-state would consist in the politician's discovery of the bomb, or at least the device's failure to detonate as planned. Similarly, a puncture might be a problem for a gang of criminals attempting to make their getaway from the scene of a crime. For the police pursuing those criminals, a punctured tyre on the criminals' car would be highly desirable.

What we should notice here is that for a particular situation or sequence of events to be designated a problem-state, someone, or some group, must judge that situation or sequence of events to be problematic. This may be subjective, where one judges for oneself that a problem exists, or objective, where the judgement is made of a third party. For example, a sincere smoker might disagree with a doctor that smoking, at least in his or her own case, is a problem. It is also possible that a person (or group) might judge themselves to be in a situation which is problematic for certain reasons, while another person (or group) judges the same situation to be problematic for quite

different reasons. This latter point might well be illustrated with an example drawn from the field of medicine. When a doctor diagnoses an illness, he or she will recognise that illness as a problem for that patient. It is, in other words, the having of an identifiable illness that is the problem from the perspective of the doctor. But for the patient, it may not be the having of the illness which is the problem, so much as the incapacity that results from being ill. For a doctor (or other health-care professional), illness can be said to be a technical problem, for there are certain objective criteria against which a doctor may assess a person's health-status¹². These criteria may not be beyond dispute - for example, a tumour is identifiable (because observable) in a way which a pain is not - but when the criteria, such as they are, are fulfilled, then the doctor would conclude that the person in whom they are fulfilled was 'ill'. This, however, might not be the conclusion of the patient. It has been shown that, of a group of people with clinically-defined illnesses, a proportion were not aware that they were 'ill' and, furthermore, did not consider themselves to be so¹³. With regard to certain diseases, the subjective/objective distinction is problematic. For example, if someone is diagnosed as HIV-positive, that person might be in a position to live a normal life for up to seven years. During this time, they are not manifestly 'ill'. They are not even diseased, strictly speaking, for the diseases that ultimately kill those HIV sufferers who develop AIDS are opportunistic, invading the body when the immune-system finally begins to collapse. This is not to deny that being diagnosed HIV-positive might be debilitating in non-

12. Andrew Twaddle, "The Concept of Health Status" in Social Science and Medicine, (1974) Vol.8, p.30

13. Innes H. Pearse and Lucy H. Crocker, The Peckham Experiment: A Study in the Living Structure of Society, (London: George Allen & Unwin, 1943), pp.95-96

physical ways. Psychological debilitation might ensue, for example, in the form of depression. It has also been argued that certain states of illness, or certain diseases, have a social dimension, such that to be labelled as a sufferer or carrier may incur costs which might prove debilitating socially or economically¹⁴.

It could be said that, from the perspective of the doctor, the patient has deviated from some biological norm - for example, an organism might be said to have invaded the body of the patient. But from the perspective of the patient the norm deviated from may well be a behavioural one - the patient can no longer act as he or she did prior to the illness. If enough tests are run on a person, some biological 'problem' can always be found¹⁵. In this sense, everyone might be said to be ill, for the simple reason that no-one is perfect. But many of these so-called 'problems' would not be problems for those to whom they are attributed, because individual lives are lived within a given set of parameters. A person might, for example, be technically overweight (where his or her weight exceeds the average for his or her height). Medically speaking, this person has a problem. But it might not be a problem for that person. He or she would almost certainly be incapable

14. Susan Sontag, Illness as Metaphor, (Harmondsworth: Penguin Books, 1983) and AIDS and its Metaphors, (Harmondsworth: Penguin Books, 1988). See also Keith Alcorn, "Illness, Metaphor and AIDS", in Aggleton and Homans (Eds.) Social Aspects of AIDS, (London: The Falmer Press, 1988), pp. 65-82

15. See, for example, the results of the 'periodic health overhaul' conducted amongst 1,206 families (3,911 individuals) at the experimental Pioneer Health Centre in Peckham, South East London, over a period of four-and-a-half years from 1938. Of the total males examined (1,946), 1,673 (86%) presented with some form of disorder, while only 273 (14%) were considered free from disorder. Of the total females examined (1,965), 1,880 (96%) presented with some form of disorder, while only 85 (4%) were considered to be free from 'disorder'. Pearse and Crocker, op. cit., pp.93-123

of running for any distance, but he or she might have no interest in running, or sport of any kind, anyway. It would be all too easy in our fitness-conscious society to accuse that person of laziness, but this would smack of the tyranny of public opinion which John Stuart Mill so detested.

A similar disjunction between public and private perspectives occurs with regard to the disabled. Quite often, what makes disabled people disabled is not their technical disability, but the social disabilities resulting from their failure to conform to other peoples' standards of normality. A person confined to a wheel-chair might experience difficulty in entering a building because the entrance can only be reached via a flight of steps. In such a case, a wheel-chair ramp would enable that previously disabled person to enter the building. The very concept of 'normality' can have pernicious consequences. But the concept of 'normality' might also have a sense which is internal to an individual. For example, for Christopher Nolan, the spastic novelist and poet, immobility and dependency are 'normal' because he has known no other condition. But for the scientist Stephen Hawking, paraplegia is abnormal since it is a condition to which his body has been progressively subjected by illness, so that physically he is not the same person that he was a decade ago. Hawking, we may say, has deviated from the social 'norm' - the norm of a healthy person - but he has also deviated from his own personal norm. Nolan, on the other hand, has never matched up to any social norm, but he has not deviated from what is, for him at any rate, a personal norm. Note that we are talking straightforwardly of physical 'normality' here. There is little doubt that Nolan as a poet and novelist is well above whatever norms might be

applicable to other people of similar age and background. Indeed, Nolan's work as a poet and novelist is acknowledged to be of a high standard quite apart from his age and background¹⁶ and Hawking, despite his illness, remains outstanding in his field.

It must be said that the notion of distinguishing between public (or social) norms and private (or subjective) norms is itself problematic for it might be the case that the sense of self one has depends upon meeting a set of socially-derived criteria; a set of standards or norms over which one may have little or no control. It is here that the notion of self-respect might be invoked, and this might be illustrated with regard to the consequences of unemployment. Whether or not employment is desired for its own sake (because it immerses one in a collective, social activity) or is simply a means to an end (consumer goods, for example), its absence appears on the whole to have a detrimental effect upon the self-esteem and morale of those who are unemployed, sometimes leading to psychiatric illness, and even suicide¹⁷. It might be said that the Conservative Party's attempt to cut back public spending involved identifying and exploiting a norm of employment, creating a climate in which those who were unemployed, for whatever reason, were made to feel uncomfortable in their predicament. Given the account of personal autonomy developed in Chapters Two and Three, it should not be surprising that what persons are or consider themselves to be has a social element to it, since the social forms with which the autonomous person engages may generate norms, or standards. Conformity to such

16. Nolan's novel, Under the Eye of the Clock, (London: Weidenfeld and Nicolson, 1987) was the Whitbread Book of the Year, 1987

17. Sean Sayers, "The Need to Work" in Radical Philosophy, (1987), Vol.46, Summer, p.18

norms is not detrimental to autonomy, and may well be constitutive of it. But it is also true that, if indeed there is such a thing as a norm specific to a person (as opposed to a norm derived from the social) then it too must be fluid up to a point, since human beings themselves change through time. The person one is at the age of five both is and is not the person one is at the age of, say, fifty. In terms of physical resemblance the difference is profound; and the person of fifty (one hopes) will have a wisdom that one lacks at the age of five. Yet there is a real sense that, these differences apart, it is the same person that has lived through the changes that have occurred. If preventive policies are to be founded upon a concern for the autonomy of persons then a greater understanding of the relationship between one's understanding of oneself as a person, and one's environment (social; cultural; and possibly even economic) will be required. This will especially be true if the account of autonomy to be employed is that developed in the first three chapters of this thesis, where the person is not simply viewed as a unity (of mind and body) but also as essentially social through his or her relationship to social forms. This may, in turn, require a more responsive social policy mechanism which can accommodate individual nuances.

V.ii: Strategies of Prevention

The subjective/objective divide is not the only difficulty that preventive policies have to overcome. Another set of difficulties arise out of one's understanding (or lack of it) of the causal processes at work in the development of illness. If prevention is a relational concept, as the above formula suggests, then preventive action will obviously depend on an understanding of the nature of the relationship

between the three variables. Furthermore, preventive strategies must pre-empt the problem-state by intervening at some point in the causal relationship that exists between the three variables. This may be done in a number of ways. First, the causal factor can be removed. For example, a nail can be picked off the road in order to prevent a puncture. Second, the physical factor could be altered in some way - the tyre could be made stronger. The medical equivalent of this strategy would be vaccination as a protection against disease. A third method might involve the erecting of a barrier between the causal and physical factors. Mosquito nets have been cited as an example of the barrier method of prevention¹⁸, but a more immediately relevant example would be the use of the contraceptive sheath as a protection against various sexually transmitted diseases. A final strategy would involve avoiding the causal factor - a person might avoid those areas of the world where malaria is rife or, in the case of the sexually transmitted diseases, might decide to become celibate. There might of course be some overlap amongst these strategies, and they will not always fit neatly into one or other of these categories. Scurvy, for example, is a disease caused by a deficiency of vitamin C. It can be prevented by eating fruit containing the necessary vitamin, or by taking the relevant vitamin supplement. To do so is simultaneously to remove the causal factor - a deficiency of vitamin C - whilst altering the condition of the person suffering from the disease.

Before any attempt at intervention may be made, however, the causal relationship must be understood. There is, of course, a wealth of philosophical speculation about the nature of causal relationships, but

18. Allsop, op. cit., p.174

such speculations are outside the scope of our immediate concerns. All that needs to be recognized here is that placing too much emphasis on certainty in our understanding of the causal processes thought to be at work in the creation of a problem-state could prove to be an obstacle to prevention. Our understanding of any causal relationship might be imperfect, while still providing us with a ground for preventive action. This principle can be illustrated with reference to the case of John Snow, a London doctor who, during an outbreak of cholera in the early nineteenth-century, noticed that people drawing water from one particular stand-pipe close to his practice contracted the disease, while those drawing water from elsewhere did not. Snow was able to recommend a course of preventive action to his patients, despite only having established a statistical relationship between cases of cholera and the contaminated standpipe. It is also true to say that some of the greatest reforms in the history of British health-care were founded upon what is now held to be an erroneous model of disease causality. The public health reforms set in motion by Edwin Chadwick's **Report on the Sanitary Conditions of the Labouring Population of Great Britain** (1842) were underpinned by its author's adherence to the 'miasmatist' theory of disease transmission. Miasmatists such as Chadwick believed that the various forms of disease were caused by 'atmospheric impurities produced by decomposing animal and vegetable substances, by damp and filth, and close and overcrowded dwellings'¹⁹ summed up in Chadwick's aphorism that 'all smell is disease'. Miasmatists held that diseases lay dormant in specific places - piles of refuse, rotting vegetable matter, human excrement, stagnant ponds and so on - where they would be activated by

19. Cited in Alasdair Clayre (Ed.), Nature and Industrialization, (Oxford: Oxford University Press, 1977), p.133

some causal factor. Views differed as to which of a range of possible causal factors might contribute to the release of the diseases contained in these 'nuisances', some arguing that inclement weather was to blame, while others argued that changes in atmospheric pressure released the diseases. Various, or in combination, lightning, thunder, rain, wind, sunshine, heat, cold, and humidity were all indicted as possible causes of disease²⁰.

Although useful preventive measures may be (and have been) derived from incomplete evidence and erroneous theories of disease-causality, the hypothetical nature of knowledge about causal relationships can also prove to be an obstacle to prevention. This is no less the case in terms of policy-formulation at the level of national government, as the example of the 1974 report on **Diet and Coronary Heart Disease** shows by the Committee on Medical Aspects of Food Policy (COMA)²¹. This report recommended, as a preventive strategy against heart disease, that the British public should be encouraged to eat less fat, and especially less saturated fat. One member of the panel, Professor John Yudkin, did not agree that the evidence warranted such a conclusion and produced a minority report registering his dissent. David, now Lord, Ennals,

20. The miasma - or pythogenic - theory of disease-causality had largely replaced an earlier influential theory based around the idea of contagion. See F.F. Cartwright, A Short History of Medicine, (London: Longman, 1977), p.97, and also below, pp.215-218

21. Department of Health and Social Security, Diet and coronary heart disease: report of the Advisory Panel of the Committee on Medical Aspects of Food Policy on diet in relation to cardiovascular and cerebrovascular disease, (Chairman: Professor Sir Frank Young). Report on Health and Social Subjects No.7, (London: HMSO, 1974). The panel reported again, reaching similar conclusions, in 1984. Department of Health and Social Security, Diet and cardiovascular disease: report of the Advisory Panel of the Committee on Medical Aspects of Food Policy on diet in relation to cardiovascular disease, Report on Health and Social Subjects No.28, (London: HMSO, 1986).

Minister for Health and Social Security between 1976 and 1979, later justified his department's apparent failure to implement the recommendations of the report on the grounds that the members of the committee had failed to reach an agreed conclusion as to the merits of the evidence presented to them²². But as we have seen, any claim to certainty, whether made by a scientist or by a lay-person, can only be as good as the available evidence will allow. Since evidence is always incomplete, there will always remain the possibility of dispute concerning a set of findings. One example of this is the tenacity with which the tobacco companies question the validity of the findings linking cigarette-smoking with a wide variety of respiratory diseases, often dismissing such findings as a mere statistical correlation. Indeed, Ennals' reluctance to act upon the findings of the COMA report goes against one of the recommendations made by the Social Services and Employment Sub-Committee of the Expenditure Committee of the House of Commons in their report on preventive medicine²³. This report, begun in 1975 and published in April 1977, recommended that:

Where a consensus exists about the dangers arising from the consumption of certain foods the Government should have a duty to bring this to the attention of the public.²⁴

In the White Paper **Prevention and Health**, which represented the Government's formal response to the Sub-Committee's report, the recommendation was subsequently accepted by the Government without reservations.

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22. Ennals' statement came in reply to a question put during a debate on the prevention of heart disease, held in the House of Lords, following publication of the 1984 COMA report. Cited in Geoffrey Cannon, **The Politics of Food**, (London: Century, 1987), pp.319-320
23. Expenditure Committee. Session 1976/77. **First Report... Preventive Medicine**, Volume I: Report, (London: HMSO, 1977)
24. Expenditure Committee, op. cit., recommendation number 45.

Since evidence is rarely, if ever, indisputable in the field of medicine, there is always likely to be the attendant problem of deciding when to accept, or decline to accept, a scientific claim. This, in the Department of Health and Social Security's publication **Prevention and Health: Everybody's Business** (1976), is referred to as 'the dilemma of uncertainty'²⁵ described as knowing 'whether or not to act on the basis of inadequate information'²⁶. But the 'dilemma of uncertainty' does not only refer to the quality of the information available to the decision-maker, for it is also recognised that the adoption of any prevention strategy might have unintended consequences. 'Today's problems,' it is suggested, 'are sometimes the consequence of yesterday's policies'²⁷, so that the adoption of any policy 'is often a matter of balancing a possible risk against a known advantage'²⁸.

Such considerations underlie two currently controversial moves relating to the quality of the food supply. The first concerns the introduction of the hormone **bovine somatotropin** (BST) into cattle to increase their milk-yields, the second concerns the process known as food irradiation. Critics of both practices point to the lack of knowledge of potential side-effects should these processes be introduced into the national

25. Department of Health and Social Security, **Prevention and Health: Everybody's Business**, (London: HMSO, 1976), pp.66-68. See also D.H.S.S., **Prevention and Health**, (London: HMSO, 1977, Cmnd.7047), para.19

26. D.H.S.S., **Prevention and Health: Everybody's Business**, p.66

27. D.H.S.S., **ibid.**, p.68

28. D.H.S.S., **ibid.**, p.66

diet²⁹. If David Emmals can be said to have treated the advice of his scientific advisors with too much caution, John Selwyn Gummer (then Minister for Agriculture, Fisheries and Food) can reasonably be said to have shown too little when he claimed, of BST, that 'nobody has any doubt about any damage being done to human beings [by BST], it is totally safe'³⁰. Of course, in view of the account of scientific methodology given in Chapter Four (**section i**, pp.151-157) it is unlikely that irrefutable conclusions will be reached on any issue. This is clearly illustrated in the case of cigarette-smoking. Of all the behaviour-related preventive issues in the field of medical care, cigarette-smoking and its implication in the causation of a wide variety of respiratory diseases is amongst the best understood. Yet despite the evidence that exists connecting cigarette-smoking with disease, the Royal College of Physicians is still compelled to write in a tentative manner, as in the following passage:

Cigarette smokers are about twice as likely to die in middle age as are non-smokers and may have a risk similar to that of non-smokers ten years older. It is estimated that over 20,000 deaths in men between the ages of 35 and 64 are caused every year by smoking in the United Kingdom. The chances are that two out of every five heavy smokers, but only one out of every five non-smokers, will die before the age of 65.³¹

Unfortunately, of course, Governments are not only ham-strung by the 'dilemmas of uncertainty'. They may also be compromised by political realities. In terms of profits from sales of tobacco on the internal

29. On BST, see Dorothy Wade's report "A country flowing with milk and drugs", The Guardian, 24th June, 1988, p.27. On irradiation see anon., "Gummer defends food irradiation proposals", The Guardian, 19th September, 1989, p.2, and subsequent correspondence - letters from Christopher Robbins (21/9/89 p.22); Dr. A. J. Swallow of the Cancer Research Campaign (22/9/89 p.18); and Prof. A. E. Bender of the Institute of Food Science and Technology (23/9/89 p.22)

30. Quoted in Wade, ibid.

31. Royal College of Physicians, Smoking and Health Now: A Report, (London: Pitman, 1971), p.2 (emphases added).

market and as exports the tobacco companies regularly feature in the top thirty British firms. Between them they employ around 27,000 workers, often in areas of general economic depression. The industry also contributes a substantial amount to Government revenue. It is unlikely that any Government would seek to antagonise such an economically important industry - one reason why voluntary agreements between Government and the tobacco industry (through its negotiating body, the Tobacco Advisory Council) are the main choice of policy instrument. Another 'hidden' economic consideration is the effect on the economy in terms of pensions and medical care should the amount of people who presently die every year from smoking-related diseases live on into old age³². There might also be straightforward electoral reasons for adopting a policy of minimal interference. An increased tax on tobacco may be a vote-loser. This argument was employed by Richard Crossman in 1967 when he argued that, since the majority of smokers were to be found amongst the working class, a Labour government that imposed a higher rate of tax on a commodity enjoyed mainly by its own supporters would be politically suicidal³³.

32. Such considerations have been voiced by an interdepartmental committee of officials drawn principally from the D.H.S.S., the Treasury, Customs and Excise, Trade and Industry. The report produced by this committee in 1971 was subsequently consigned to limbo, until a copy was leaked to The Guardian newspaper in 1980. G.T. Popham, "Government and Smoking: Policy-Making and Pressure Groups" in Policy and Politics, (1981), Vol.9(3), pp.344-345

33. Popham, ibid., pp.335-336

V.iii: Prevention and Health Policy

The **Prevention and Health** campaign, launched under a Labour Government in 1976, was intended to 'stimulate discussion on the possible contributions of prevention towards the solution of our health problems'³⁴. It was aimed at a wide audience, including those involved with aspects of 'environmental health, food standards and the education and social services', in fact, all those services 'which have significant effects on the nation's health'³⁵. This, of course, also included the (then newly-reorganised) National Health Service. The publication of the discussion document, **Prevention and Health: Everybody's Business**, was described in the White Paper **Prevention and Health** published the following year as marking 'an unequivocal change of policy within the Health Departments towards prevention'³⁶. Yet it has been remarked that the most striking aspect of this change in policy was not so much the advocacy of prevention as a means of tackling health problems, but rather the emphasis placed on the role of the individual in this respect³⁷. This theme, as we have already noticed, runs throughout the series of documents published under the **Prevention and Health** rubric. However, the stress on individual responsibility must be put into an overall context of medical care. For example, in the document **Priorities for Health and Personal Social Services in England** (published in 1976, the same year as the **Prevention and Health** campaign was launched), preventive health care is seen as part of an overall strategy, centred around the primary health care team³⁸. Primary health

34. D.H.S.S., **Prevention and Health: Everybody's Business**, p.6

35. D.H.S.S., **ibid.**

36. D.H.S.S., **Prevention and Health**, para. 12

37. Allsop, **op. cit.**, p.179

38. D.H.S.S., **Priorities for Health and Personal Social Services in England: A Consultative Document**, (London: HMSO, 1976)

care, as it is understood in this document, incorporates four main categories of general medical provision - general medical services, general dental and ophthalmic services, pharmaceutical services, and a fourth category covering services provided by health centres and family planning clinics. This last category also includes general prevention, such as health education. The stated intention of this document was twofold. Firstly, it was designed to stimulate local health authorities to giving more thought, and more resources, to preventive activities. But secondly, and even more importantly, was the need 'to bring home to everyone how much they can do to improve their own health and that of their family'³⁹. These are, of course, the stated aims of the **Prevention and Health** campaign proper. To illustrate its commitment to prevention, the government was able to point to an increase in the 1975/76 budget of 400% over the 1970/71 budget for some preventive services, specifically those concerned with immunisation, vaccination, fluoridation and family planning. This increase must be set against the total health care expenditure, where these preventive services received only £40m or 4.2% of the total amount spent (against £10m or 1.6% of the 1970/71 budget). A more modest rise was anticipated for the 1979/80 budget, with preventive services increasing by another 33% over the '75/76 figures, to total 4.8% of the overall budget⁴⁰.

The White Paper, **Prevention and Health** (1977, Cmnd.7047), offered a tripartite definition of prevention:

Prevention in relation to health is either an attempt to prevent disease or disability before it occurs (primary prevention), the early detection and treatment of conditions with a view to returning the patient to normal health

39. D.H.S.S., op. cit., para.3.23

40. D.H.S.S., op. cit., fig.3, p.21

(secondary prevention), or the continuing treatment of disease or disability to avoid needless progression or complications (tertiary prevention).⁴¹

This threefold definition was not specifically developed for the campaign and although it may be comprehensive in scope it is not categorical but rather admits of a number of 'subtle but significant differences of interpretation'⁴². These differences of interpretation, it is suggested, lead to a 'blurring' of the distinctions between the three modes prevention. For our purposes, however, the most interesting blurring that occurs concerns the distinction we have already noted between 'preventive' and 'curative' medicine, whereby the latter can be redescribed as a branch, or sub-division, of the former. This is brought out more clearly if one considers Sir Richard Doll's claim that the objectives of preventive medicine are two-fold. His claim is that preventive medicine aims at (i) the prologation of life (or, to put it another way, the avoidance of death), and (ii) the reduction of disability⁴³. If an illness is either disabling in any way, or life-threatening, or both, then to cure that disease is to prevent disability or death. Hence curative medicine is also preventive medicine. This leads us to consider what the point of the tripartite distinction might be.

41. D.H.S.S., Prevention and Health, (London: HMSO, 1977, Cmd 7047), Appendix II: "Definition of Prevention".

42. Andrew Tannahill, "Reclassifying Prevention" in Public Health, (1985), Vol.99, pp.364-365. Tannahill notes that the tripartite definition of prevention can be traced back to 1961.

43. Sir Richard Doll, "Preventive Medicine: The Objectives", The Value of Preventive Medicine: Ciba Foundation Symposium No.110, (London: John Wiley, 1985), p.3

One suggestion is that it enables us to establish the foci of specific preventive practices⁴⁴. Thus it might be said that tertiary prevention is the job of those health professionals concerned with rehabilitation - osteopaths, for example, or psychiatrists - or with the care of those suffering from chronic complaints such as Alzheimer's disease, or terminal cancer. Secondary prevention might be the province of general practitioners (administering vaccines; performing cervical smears etc.) or any other set of people who perform these functions (health visitors; community nurses; and others). Primary prevention can be said to involve a wide range of people and institutions, from health professionals (doctors; health educators; midwives) through local government employees (environmental health officers) and others (the police force; water boards) to the national government (through, for example, legislation). One of the most important points that both the White Paper and the document **Prevention and Health: Everybody's Business** sought to establish was that, in terms of primary prevention, individuals themselves had a far greater role to play⁴⁵.

But if the point of the tripartite schema is to locate the onus of responsibility for specific preventive practices, then the blurring of distinctions pointed to above also has the correlative effect of making this task less straightforward. Doctors, for example, may be said to involve themselves in all three categories of prevention. They might (in conjunction with the home-visiting services or the patients own family) involve themselves in the care of the chronically ill. They certainly involve themselves in many of the activities falling under the rubric of

44. Tannahill, op. cit., p.365-366

45. D.H.S.S., Prevention and Health, para.287; D.H.S.S., Prevention and Health: Everybody's Business, p.95

secondary prevention, and have recently been encouraged to play a far greater role in primary prevention than they already do⁴⁶. It has also been pointed out that some interventions are difficult to place within the tripartite schema. Treatment of an haemophiliac might be called tertiary prevention from the point of view of the patient, but primary prevention from the point of view of the patient's relatives and friends⁴⁷.

It might also be the case that the schema fits certain types of health problem better than others. This is implied in a recent report of the Advisory Council on the Misuse of Drugs, which stated that the traditional three-part schema was not 'sufficiently comprehensive for all elements of prevention policy'⁴⁸. In view of the foregoing discussion, it is significant that the Advisory Council, in developing a more comprehensive account of prevention, chose not to increase the number of categories, but instead to reduce them proposing a bipartite distinction:

- a. reducing the risk of an individual engaging in drug misuse,
- b. reducing the harm associated with drug misuse.

Were this to be applied to the field of medicine, we would see that the first of these criteria accords with primary prevention - which, as we have seen is concerned with preventing disease or disability from arising in the first place - while the second criterion accords with both secondary and tertiary prevention - which may both be said to

46. D.H.S.S., Promoting Better Health, para.3.18 and para.1.15

47. J. Griffiths; J. Dennis; P. Draper; J. Popay, "Concepts of Prevention" in Clark and Henderson (Eds.), Community Health, (London: Churchill Livingstone, 1983), p.20

48. Home Office, Prevention: Report of the Advisory Council on the Misuse of Drugs, (London: HMSO, 1984), Section 1; para.11

concern themselves with the management of disease or disability, once that disease or disability has arisen.

One way in which the discussion so far might be summarised would be to say that while all curative medicine is also preventive, not all preventive medicine is curative. Of the three categories, it is specifically primary prevention that has no curative content at all, while the other two categories - both secondary and tertiary prevention - essentially aim to cure, or return the individual to health. This is not to say that these two categories are concerned solely with curing patients. We have already seen that tertiary prevention, for example, includes the care of those suffering from chronic diseases. It also covers the management of currently incurable diseases, such as mental disorders (schizophrenia, for example), and diabetes mellitus⁴⁹. If the point of the tripartite definition of preventive health-care is intended to delineate responsibilities for the various classes of preventive activity it covers, it also paradoxically masks an important point concerning responsibility which the bipartite definition uncovers. For, if both secondary and tertiary prevention assume the presence of a disease or disability, then both of these categories, almost by definition, are the province of the medical profession itself (bearing in mind that the medical profession is 'demand led'). Primary prevention, on the other hand, is not - at least not necessarily. Primary prevention comprises a vast range of activities from the elaborate (the passing of legislation through Parliament, for example, in order to ensure clean water supplies) to the mundane (looking both ways before one crosses the road). These activities themselves may be

49. D.H.S.S., Prevention and Health, p.82

carried out by a wide range of people, from individuals to Government officials. Secondary and tertiary prevention also encompass a vast range of activities, from the elaborate (cardiac by-pass operations; heart transplants, and so on) to the mundane (the prescribing of anti-biotics), but these activities are carried out by a fairly narrowly-defined set of people - the medical profession. Hence, secondary and tertiary prevention are essentially professional categories; primary prevention is not. In other words, it is primary prevention - and not secondary or tertiary prevention - that is, to coin the phrase, everybody's business. Despite the allusion here to the flagship document of the **Prevention and Health** campaign, the documents published under that rubric are generally concerned with one particular sphere of responsibility - that of the individual.

Although we refer to the series of documents published under the **Prevention and Health** rubric as a 'campaign', very little coherent policy activity resulted. In 1984 an attempt was made to produce a systematic review of the fate of the fifty-eight proposals made in the report of the Sub-Committee of the Expenditure Committee on preventive medicine to which the White Paper **Prevention and Health** was the Government's formal response⁵⁰. Not all of the Sub-Committee's proposals were endorsed by the government at the time. Of the fifty-eight proposals made by the Sub-Committee, only twenty-four were accepted without reservation. Eight were rejected altogether, while the rest were accepted 'with reservations' or were said to be 'under consideration'.

50. J. Henderson and D. Cohen, 'No Strategy for Prevention' in Harrison and Gretton (Eds.), **Health Care U.K. 1984, An Economic, Social and Policy Audit**, (London: Chartered Institute of Public Finance and Accountancy, 1984)

In conducting their review, Henderson and Cohen concentrated only on those proposals that had been accepted outright and were not either 'too vague for meaningful investigation...or...for which information could not readily be obtained.' It was discovered that, where proposals had been implemented, as in the case of immunisation, sex education and the keeping of age/sex registers, the benefits in terms of improvements in health were generally of limited value. In areas where more than one proposal was made, such as health education, there appears to have been a failure to co-ordinate the implementation of policies. For example, spending on health education through the Health Education Council increased between 1977 and 1982, but this was not backed up by a concerted attempt to persuade the medical schools to give the topic of health education a higher profile in their training courses. The Royal College of General Practitioners (RCGP) now publishes information on health education for its members, but it appears not to monitor the effectiveness of this strategy in raising public awareness of health issues. In some instances there appeared to be little or no policy at all. Food policy, as Henderson & Cohen note:

...consists of ensuring informed choices freely made by members of the public. But when it comes to providing the necessary information, the Departments seem reluctant to take a stand on any issue where evidence is not irrefutable.⁵¹

Even where advice was offered, as in the document **Prevention and Health - Eating for Health** (1978), it was often too vague to be of any practical use⁵².

51. Henderson and Cohen, op. cit., p.65

52. The British Medical Association's Board of Science and Education said of this document that it 'is not a practical statement of dietary change since it neither indicates whose eating habits should change, nor by how much'. British Medical Association, Diet, Nutrition and Health: A Report of the Board of Science and Education, (London: BMA, 1986), p.5

V.iv: Prevention and Models of Disease-Causality

One of the most salient criticisms of the general approach to prevention outlined in the series of documents published under the **Prevention and Health** rubric focusses on the model of disease-causality that is said to underlie it. We have already noticed the importance of theories of disease-causality to preventive action. For example, we saw that Chadwick's nineteenth-century public health reforms were informed by the miasmatist, or pythogenic theory of disease causality. This was not the only theory of disease-causation available to Chadwick and his contemporaries. There were at least three others of note. The major rival theory to the miasmatists' was the 'contagionist' theory which held that diseases were transferred through direct contact with the diseased person or his or her clothing, personal effects, and so on. Each theory gave rise to different political and practical 'solutions' to epidemics of disease. Miasmatists argued for the removal of 'nuisances', for clean air and ventilation, and so on. Contagionists, on the other hand, favoured quarantine as the chief barrier against the spread of disease. The contagionist theory dominated at the time of the first two cholera epidemics of 1831-1832 and 1848-1849. A third theory, known variously as the moral, biblical, or (a contemporary term) the fundamentalist model, proposes that disease is both evidence of, and punishment for, moral depravity⁵³. Archaic as this might seem, it has recently been revived, in the context of the HIV/AIDS epidemic, by some christian fundamentalists seeking to demonstrate to those still unconvinced that homosexuality is against the will of their particular god. This project has once more been discredited following the spread of

53. See, for example, John Wesley's Primitive Physick: or, An Easy and Natural Method of Curing Most Diseases, (1749: Reprint, London: G. Woodfall, n.d.), p.111

HIV/AIDS to otherwise 'innocent' groups of people such as haemophiliacs, unsuspecting female sexual partners of male sufferers, and victims of rape. A fourth theory, developed against the context of late-nineteenth-century romanticism, emphasised the role of personal behaviour. The romanticisation of nature in the face of apparently deforming industrialisation led some to attribute sickness and disease to unnatural lifestyles and to recommend natural techniques and remedies for illness against artificial, scientific remedies⁵⁴.

The twentieth-century debate about the cause of disease has turned on two models - the medical model, and the environmental model. Of these, the former is generally said to dominate within the medical profession (hence its name) but it is also said to underlie Governmental policies in the field of health care⁵⁵. Broadly speaking, the medical model holds that disease has, in principle, a single causal factor such as a virus, or germ. Indeed, the model is sometimes known as the 'germ theory'⁵⁶. This causal factor locates in the body of an individual, and gives rise to various symptoms which may assist in the identification of the virus or germ. Diseases, then, are held to have specific individual aetiologies, requiring specific individual cures. The body of the individual is the ultimate focus of any attempt to cure disease. Once a disease has been identified, the responsibility for that disease devolves to a socially-recognised expert - e.g. a doctor - for

54. Sylvia Noble Tesh, Hidden Arguments: Political Ideology and Disease Prevention Policy, (New Brunswick, N.J.: Rutgers University Press, 1988), pp.18-19

55. Peter Townsend, "Individual or Social Responsibility for Premature Death? Current Controversies in the British Health Debate" in International Journal of Health Services, (1990), Vol.20(3), p.378

56. Tesh, op. cit., p.38

treatment⁵⁷. Although the medical model is widely employed by the medical profession, its explanatory value is open to criticism, for not all diseases fit into the requisite framework. Cancer provides one example of a disease for which no single organism - virus or germ - has been identified as a causal factor. We have already remarked that one reason underlying the Government's interest in prevention during the mid-nineteen seventies was the curative emphasis of the National Health Service. This emphasis can partly be explained by the medical profession's adherence to the medical model of disease-causality, for, as Sylvia Tesh has remarked, the medical model 'is more directly applicable to the treatment and cure of diseases than it is to their prevention'⁵⁸.

The main alternative to the medical model of disease causality is the social, or environmental model. If the medical model locates the source of disease in the body of the individual, the social model locates it outside of the individual, in the social or cultural environment. If the medical model sees health as a negative state - as an absence of disease - the social model sees health as a positive state of well-being⁵⁹. One distinct advantage of the social model is that it can incorporate most of the diseases that the medical model applies to (especially those that are transmissible from one individual to another) and many others that the medical model fails to account for. For example, the social model can account for diseases such as cancer, and ischaemic heart disease,

57. Raymond Illsley, "Everybody's Business? Concepts of Health and Illness", Health and Health Policy, Priorities for Research, Social Science Research Council, 1977, Appendix 4, p.3

58. Sylvia Noble Tesh, "Disease Causality and Politics", Journal of Health Politics, Policy and Law, (1981), Vol.6(3), p.374

59. Townsend, ibid., p.378

where no germ or virus is to be found. The social model can also incorporate the notion that health and illness might be functions of income, class, and opportunity⁶⁰. It is this latter point that leads us into a consideration of the political implications of each of the two models, for, if the medical model more appropriately emphasises curative practices, it might seem that the social model more appropriately suits preventive policies. While this might be true in theory, in practice it is not the case.

V.v: Prevention, Politics and Responsibility

It is sometimes suggested that the dominance of the medical model over other theories of disease-causality can be explained in terms of the implications it holds for the construction of health policies. Tesh, for example, points out that the medical model has the advantage of simplicity over the social model⁶¹. In order to overcome disease the medical model requires only changes in individuals, since it both focusses on individuals in the search for disease and operates upon individuals in curing disease. The social model, on the other hand, may call for changes in the structure of society. In this respect, the social model represents a 'frankly political' approach to health care, in that it tends to hold the owners and managers of industry largely responsible for the ill-health of the population. It is for this reason that the social model has come to be associated with the political 'left' since it often implies a critique of the capitalist mode of

60. Tesh, Hidden Arguments, p.49

61. Tesh, "Disease Causality and Politics", p.373

production⁶². It is essentially because of the focus on the individual that it is plausible to claim that the medical model of disease-causality underpinned the policy-shift towards prevention, signalled by the **Prevention and Health** campaign in the mid-nineteen seventies.

We have already noticed (above p.191) that the idea of prevention has cross-party appeal. But consideration of the implications of these two models of disease-causality demonstrates the contentious nature of prevention, for each model gives rise to radically different policies. Indeed, some frankly acknowledge that adoption of the social model would literally have 'revolutionary implications'⁶³. At the very least, preventive policies become politically contentious⁶⁴. Emphasis placed on individual responsibility means that attention is diverted away from industrial and environmental sources of disease. Attention is also diverted away from economic sources of disease, for it is not only pollutants from factories that cause disease, but also poverty⁶⁵. The

62. See, for example, Joseph Eyer and Peter Sterling, "Stress-Related Mortality and Social Organisation", The Review of Radical Political Economics, (1977), Vol.9, Spring, pp.1-44. See also Vicente Navarro, Crisis, Health, and Medicine: A Social Critique, (London: Tavistock, 1986), pp.164-170

63. Townsend, ibid., p.378

64. Rosemary Taylor, "The Politics of Prevention" in Social Policy, (1982), Summer, p.33

65. The connection between poverty and ill-health was demonstrated by a Parliamentary Research Working Group, chaired by Sir Douglas Black, set up in 1977 by David Ennals, then Secretary of State for Social Services. The Working Group's report, published by the D.H.S.S. under the title of Inequalities in Health, (London: HMSO, 1980) but known popularly as The Black Report established that material deprivation was the single most important (but by no means the only) contributing factor to the significantly higher rates of illness amongst the poorer sections of the population. Townsend, ibid., pp.384-385. The findings of The Black Report were recently supported by the British Medical Association's Board of Science and Education report, Deprivation and Ill-Health, (London: British Medical Association, 1987). The latter document is interesting since it shows the medical profession itself utilising the social model of disease-causality.

ability of individuals to change their behaviour may, in part, be a function of their economic status, but it might also depend on their social status as well. Cultural influences have, for example, been shown to play a part in the ability of certain social groupings to give up smoking⁶⁶.

A second consequence of the individually-focussed medical model of disease causality is that, in ignoring the wider industrial, economic and social causes of disease, the individual comes to be held, inappropriately, responsible for his or her own health. This practice has been described as 'blaming the victim'⁶⁷, a practice that - potentially, at any rate - 'serves to reorder expectations and to justify a retreat from the language of rights and the policies of entitlements'⁶⁸. The suggestion is that those individuals who deliberately indulge in health-threatening activities, could conceivably be denied access to health-care facilities. One problem with this is that it ignores what has already been called 'the dilemma of uncertainty' - a phenomenon deployed in the **Prevention and Health** documents to explain and justify caution on the part of the Government in implementing certain policies. Here, we may turn the phenomenon in

66. For example, the White Paper, **Prevention and Health**, recorded that reductions in the numbers of people smoking manufactured cigarettes were greatest amongst professional workers, and greatest of all amongst doctors. Smoking generally continued to be more prevalent amongst social classes III, IV, and V, and heaviest amongst the latter, with little reduction taking place in the numbers of women smokers, and even, in social classes III and V, an increase in the numbers of those smoking. Para.52 and page.15, fig.3

67. William Ryan, **Blaming the Victim**, (New York: Vintage Books, 1976); Robert Crawford, "You Are Dangerous To Your Health: The Ideology And Politics Of Victim Blaming" in **International Journal of Health Services**, (1977), Vol.7(4), pp.663-680; J. P. Allegrante and L. W. Green, "When Health Policy Turns to Victim Blaming", **New England Journal of Medicine**, (1981), pp.1528-1529

68. Crawford, **op. cit.**, p.668

favour of the individual in the following way. Since not all smokers develop lung-cancer, and not all those who develop lung-cancer are smokers, establishing a link between the fact that a given individual smokes and that he or she has developed lung-cancer must depend, in part, in establishing that he or she would not have developed the disease had they not smoked. This is clearly impossible to do. Given the existence of such 'dilemmas of uncertainty' it would seem to be unjustifiable to hold individuals responsible, in any strong sense, for the state of their health. Resorting to a weaker sense of responsibility does not help. If smokers who develop lung-cancer are to be penalised because they knew that smoking increased the risk of ill-health, then there seems little reason not to refuse medical care to the hang-glider pilot who is injured in an accident. After all, hang-glider pilots know that there is a risk involved every time they launch themselves from a mountain-side.

There are two other areas where 'blaming the victim' might have important consequences. The first of these areas concerns the obtaining of life-insurance⁶⁹. Insurance companies, for some time now, have required that applicants for life-insurance declare whether or not they smoke. If they do, then a premium may be payable in order to counter the increased risk of developing any one of the range of diseases connected with that activity. The smoker is thus penalised for smoking, ostensibly on the grounds that the smoker has a choice as to whether or not he or she smokes, whereas the non-smoker, who might nevertheless be susceptible to these diseases, does not have a choice as to his or her

69. Crawford, op. cit., pp.669-671; Deborah A. Stone, "The Resistable Rise of Preventive Medicine", Journal of Health Politics, Policy and Law, (1986), Vol.11(4), p.676-677

own susceptibility. This ignores the addictive nature of cigarette-smoking (many smokers take up the habit when they are not mature enough to understand the dangers of smoking). It also ignores the pressures, both social (for example, from one's peer-group) and commercial (for example, cigarette advertisements) that may influence one to take up the habit in the first place. More recently, insurance companies have sought to raise the premiums for those groups currently defined as 'at risk' from HIV/AIDS⁷⁰.

The second area concerns employment. It has been pointed out that in the United States of America, the practice of 'medical screening' is increasingly being used by employers to 'weed out' those members of the work-force who are deemed susceptible to life-style, or behaviour-related diseases. This benefits the employers by reducing absenteeism and the costs associated with this, including health and disability insurance costs, and possibly even compensation payments to workers⁷¹. However, the benefits to be derived from 'weeding out' employees are uncertain, since any financial savings must be set against the cost of the vetting procedures. Health tests of the kind necessary to detect life-style or behaviour-related diseases are often technologically sophisticated, and the staff required to conduct such tests will also incur additional expense. Costs might actually increase if companies had to spend more time vetting prospective employees. It has also been pointed out that, given a plentiful supply of potential employees and a

70. Anon., "Lifestyle Insurance", The Guardian, 2nd May, 1987, p.23

71. Stone, op.cit., p.683-685. While this argument may not be immediately relevant to the United Kingdom, it is nevertheless the case that many companies and businesses in the United Kingdom make the offer of employment conditional on the completion of a medical examination.

diminishing demand for skilled labour, an unhealthy workforce might ultimately help to reduce costs by reducing the amount of money paid to workers who have retired, or who have been disabled through injury⁷². Despite the ambiguities inherent in the idea of 'blaming the victim', it nevertheless surfaces now and again in British politics. A recent example would be the statements by a representative of Government suggesting that the rise in instances of domestic food-poisoning may be attributed to poor hygiene in the home, rather than to poor hygiene in the food-processing plant⁷³.

Conclusion

In this chapter we have examined in some detail a specific area of health policy. In **section i** we examined the concept of prevention. Since prevention is a relational concept, by exploring the relationship between the three variables (causal factor; physical factor; problem-state) of which it is comprised, we were able to identify some of the problems that preventive policies might generally be expected to encounter. One problem, of relevance to our discussion of personal autonomy, concerns the norms or standards employed in defining a situation as problematic, for there may be a gap between public (or objective) and private (or subjective) accounts of what comprises a problem-state. There might be general agreement over many health-related issues (for example, few people in a society such as ours, regardless of

72. Neil A. Holtzman, "Prevention: Rhetoric and Reality", International Journal of Health Services, (1979), Vol.9(1), p.35

73. Sir Donald Acheson, Chief Medical Officer to Her Majesty's Government, issues guidelines to housewives on how to minimise chances of food poisoning. Reported by Aileen Ballantyne; Owen Bowcott; Michael Smith, "Government launches food poisoning enquiry", The Guardian, 11th February, 1989, p.1

the level of autonomy they have achieved, would regard the existence of a cancerous tumour as anything other than a problem-state) but if, as we have suggested, health is tied to autonomy, there may be room for disagreement. For example, some religious persons might view illness as just punishment for the sins they have committed. The problem-state then would be their behaviour, and not necessarily the illness. In designating a particular situation as a 'problem-state' a government (or the medical profession, or whoever is charged with developing preventive policy) might have the effect of over-riding individual autonomy at some point. Of course, such occasions might be justified on the basis of a distinction (such as Young makes) between 'occurrent' (or short-term) autonomy and 'dispositional' (or long-term) autonomy⁷⁴. But this distinction is itself problematic since it too only attains relevance in the light of a person's plans and projects and there is no reason why these should not be fluid and imprecise, and subject to revision and alteration. This is not solved by making reference to the social forms one engages with either, since we assume that autonomous individuals may disengage from these when they so wish, and providing that it is within their power to do so. The imposition of norms and standards is potentially authoritarian and this, of course, is partly what autonomy-based theories are designed to avoid⁷⁵.

Another set of problems turn on understanding the causal relationship that holds between the three variables. Aspects of this problem were discussed in **section ii** and **iv**. In **section ii** we suggested that, despite philosophical problems with the idea of causality, it was not always

74. Robert Young, Personal Autonomy: Beyond Negative and Positive Liberty, (London: Croom Helm, 1986), pp.72-75.

75. Introduction, **section i**, p.10

necessary to have fully grasped the nature of the relationship between the variables before preventive action could be taken. However, in **section iv**, where we discuss models of disease-causality, an understanding of the nature of the relationship between the three factors assumes some importance. This is because different models of disease-causality entail different views as to where the locus of disease, and also of responsibility for disease and disease-prevention, must fall. This consideration has political implications in terms of the kinds of policies ultimately adopted, as we saw in **section v**. But it also has implications for autonomous individuals in the kind of assumptions that are made about those at whom preventive policies are aimed. For to allocate to persons responsibility for their health is also potentially to allocate to those same persons blame for their ill-health. Thus the criticism made of preventive programmes that they 'blame the victim'⁷⁶ can be seen to follow from an erroneous understanding of those persons who are the subject of preventive policies. For example, the **Prevention and Health** campaign (discussed in **section iii**) appears to have assumed that those individuals at whom the documents were aimed had achieved an adequate level of autonomy. But the kind of autonomy assumed appears to have been of the types criticised in Chapter Three (**sections iii** and **iv**), where there is little or no reference to the wider (i.e. social, cultural, political, or economic) context within which the 'autonomous' individuals are located.

76. This chapter, **section v**, pp.220-223. Judith Allsop notes that in certain areas, preventive policies appear to treat individuals as responsible, motivated, and self-reliant at one level, and as helpless addicts at another. Cigarette-smoking, for example. Allsop, op. cit., pp.180-181

This last point suggests that a more thoroughgoing set of preventive policies would have to take into account the context within which individuals operate. This in turn suggests that some version of the social model of disease causality would need to be employed in the development of preventive policy, and of health policy generally. After all, the health of autonomous persons is not solely determined by their own actions. Autonomous persons should not just be viewed as a unity of mind and body, but also as situated in an environment. In this respect, the 'heroic' view of individuals adopted by the **Prevention and Health** campaign, and the corresponding assumption that the imparting of information is of itself sufficient to improve the health of the nation, is clearly inadequate.

Conclusion

In this conclusion we review the principal points that have been established in the preceding five chapters. We first of all consider the implications for the project of employing autonomy as an 'organizing principle' for social policy of the particular account of personal autonomy developed in Chapters One to Three. We then consider the implications for theories of medicalization of adopting this account of autonomy. We then examine, from the perspective of personal autonomy, a specific policy-area - preventive health-care. We conclude finally with some general comments about the overall project of employing an account of autonomy as an organizing principle for social policy, and of the kinds of policies that might result from this.

* * * * *

The problem initially identified in Chapter One focussed on the alleged 'essential contestability' of the objectives of social policy. Since there are many possible objectives, some means of arbitrating amongst them was seen to be desirable. The option explored in this chapter was that of utilising one of the many possible objectives of social policy as an 'organizing principle' around which social policy would be formulated. Two frequently-cited candidates for this task - the alleviation of need and the securing of liberty - were discussed and rejected. Both were seen to require some further argument as to which needs and liberties (of many possible options) would be deserving of social concern, and which would not. Two further candidates for the role of organizing principle were then discussed. First, Rawls' neo-Kantian argument, set out in his A Theory of Justice, was discussed. Rawls considers that the principles upon which a just society may be

constructed can be chosen from behind a 'veil of ignorance'. This was shown to be deeply problematic, mainly because the individuals who are to decide the principles of justice are required to abstract themselves from the society of which they are both a part and a product. Rawls' Kantian assumptions, it seems, get the better of him at this point since it is by no means clear that persons could get themselves into the 'original position' without ceasing to become persons in any meaningful sense. The second theory discussed was that developed by Plant, Lesser and Taylor-Gooby in their Political Philosophy and Social Welfare. These authors, utilising a reflexive argument, propose that autonomy be employed as an organizing principle for social policy. One immediate advantage of focussing on some notion of autonomy is that it acknowledges the subjective nature of the good - that which is of value to individuals. Thus, focussing on some notion of autonomy appears, on the face of it at least, to provide a means by which the authoritarian implications of those social and political theories that posit an objective good might be avoided.

Plant et al suggest that since it is taken to be characteristic of human beings that they are, or are potentially, capable of moral agency, then the conditions necessary for autonomy (understood as moral agency) could provide a framework within which social policy might be fitted. The authors themselves propose four basic conditions necessary for autonomy - survival (since if there were no people there could not be moral agency); freedom from arbitrary exercises of power; freedom from ignorance; and freedom from ill-health. The difficulty with Plant et al's argument lies in its focus on the moral capacities of persons. The concept of moral autonomy can itself be seen to derive from Kant whose

theory is liable to those same criticisms already levelled at Rawls. The Kantian concept of moral autonomy is formal and abstract. It requires the decontextualising of individuals, and this, we argue, is inadequate as a ground for social policy. We therefore proposed that the Kantian notion of moral autonomy be rejected in favour of some notion of personal autonomy and in Chapter Two we proceeded to examine one such account.

Taking Plant et al's claim that moral agency is (potentially at least) a characteristic of persons as our starting point, in Chapter Two we demonstrated that, unlike moral autonomy, personal autonomy was neutral amongst moral theories. Moreover, personal autonomy was itself shown to be a prerequisite of moral agency. Kant, for example, equated moral autonomy with acting morally, but some notion of autonomy must also underpin immoral behaviour, and our account of personal autonomy is shown to fulfil this criterion. Having established that personal autonomy is more fundamental than moral autonomy, we then turned to an examination of the nature of the relationship that might be thought to exist between autonomous persons and their environment. This took the form of a critical appraisal of Joseph Raz's account of the relationship between autonomous persons and 'social forms' as set out in his The Morality of Freedom. Although flawed in a number of ways, Raz's account of 'social forms' nevertheless serves to demonstrate that autonomous persons must be understood in relation to a social context, since it is this social context that is partly constitutive of their autonomy (for example, it may shape the choices they have). This indicates that the account of personal autonomy developed by us can avoid the accusations of individualism that are sometimes levelled at liberal theories because

it has a social element to it. One possible advantage of emphasising the social nature of personal autonomy in this way is that it more easily lends itself to the task of providing a substantive organizing principle for social policy (against, for instance, the formal abstraction of Kantian models). In Chapter Three, this possibility was explored in the context of a discussion relating autonomy to health, and to health policy.

The argument in favour of contextualisation (and against accusations of individualism) was also pursued, in Chapter Three, through a discussion of the idea of independence, associated with some libertarian thinkers (Wolff, in our case, but Sartre in his pre-marxist phase would do as well). Our account of personal autonomy led us to conclude that too high a level of independence is untenable, especially in a complex world such as ours. There is no reason, for example, to expect autonomous persons to display an inordinately high level of independence because autonomous persons may choose to define themselves either by their commitments or by their submission to authority (or both of these) rather than their rejection of these things. Given the costs involved in, say, gathering and checking information, it follows that autonomy might be fostered by inter-dependence, rather than independence.

Plant et al claim that freedom from ill-health is one of the conditions necessary for moral agency. In Chapter Three we considered whether or not there might be some such link between health and our account of personal autonomy. Health-care, as we noticed at the time, is one of the largest policy-areas. If our account of personal autonomy is to be utilised as an organizing principle for social policy, it would seem to

be important to establish two things: first, that health is indeed relevant to personal autonomy (this is assumed to be the case by Plant et al's, though they do not attempt to examine the connection) , and second, what the nature of the relevance is. In order to establish that there is a link, we argued that certain 'intellectualist' accounts of autonomy would have to be rejected. This was explored through the notion of a 'rational self'. One reason for rejecting some hypotheses of the 'rational self' is their association with the Kantian notion of moral autonomy, already rejected in Chapter One. However, we concentrated instead on a legacy, bequeathed to us by the seventeenth century French philosopher, Rene Descartes. This philosopher posited two irreconcilable facets of persons - mind and body - of which the former is the more fundamental of the two. Something of Descartes' project survives in the tendency of some accounts of autonomy to posit an 'inner' self, or a mental entity, as somehow more 'real' than the physical, or rather the embodied self. Our argument demonstrated that personal autonomy must be understood as a capacity of the whole person. This was shown to be because autonomy is not only about choosing from amongst a set of options, but also about implementing one's choice. In order to implement one's autonomously chosen objectives, one must express oneself through the medium of one's body within a social setting. It is in this context that the condition of the body, or health, can be seen to be important to autonomous persons. It is on this basis also that health comes within the ambit of social policy.

What remains unclear, however, is the precise nature of the relationship between autonomy and health. For example, it seems relatively clear that autonomous persons might choose to sacrifice their health for the sake

of some other goal, even to the extent of giving up their lives for the sake of others, or some cause that they have (autonomously) aligned themselves with. The importance of health will therefore be relative to the plans or projects that autonomous persons develop or adopt. But if this is the case, then a problem arises for the project of utilising this account of autonomy as an organizing principle for social policy. For example, it is unclear how one is to utilise autonomy as a guide to distributing finite resources amongst a given population. For if health is important to autonomous persons in that it affects their ability to make and implement autonomous choices, it follows that different levels of health and different kinds of health will be important to different people since the plans and projects individuals have will be specific to them. For example, an athlete will require a high standard of physical health in order to achieve his or her objectives, while a person who occupies a sedentary and academic post will not necessarily require the same standard of physical health.

Of course, it might be objected that, in terms of health policy, the point is not to foist athletic fitness upon everybody, but simply to cater for a basic standard of health. Yet even the notion of a basic standard of health is problematic from the point of view of autonomy because it is unclear what level of autonomy is to be aimed at by health policy. Few people, if any, lack all opportunity to make and implement autonomous choices (if they did, they would hardly qualify as persons at all) so that even the most apparently unhealthy of persons might be in a position to make some autonomous choices. There is also no clear relationship between the standard of health one enjoys and one's capacity to exercise one's autonomy. One might, for example, be in peak

physical condition but be unable to read, appreciate music, write, and so on, so that one's options are considerably narrower than those of a person less physically fit, but literate. One might also be superbly fit, but as a consequence of being brainwashed into believing that one 'wants' to be an athlete. These last two examples, of course, represent (respectively) ignorance and arbitrary exercises of power and these, alongside ill-health, are taken by Plant et al to be conditions under which autonomy is curtailed. It may be that, in focussing in this thesis on only one of the conditions (health) said to be necessary for autonomy, we present an unreasonably distorted picture of the relationship between autonomy and social policy. It may be that a more integrated social policy (one, that is, that takes account of the other 'basic conditions' identified by Plant et al) would be required in order adequately to foster autonomy.

The idea of a standard of health is problematic for another reason. For as one's health either improves or deteriorates, one might re-assess one's plans and projects in the light of one's present condition. Alterations in the standard of one's health might also raise (or lower) one's expectations, so that what might have been thought an adequate standard of health at some earlier point might become inadequate at some later point. This itself might pose a serious problem for the project of utilising personal autonomy as an organizing principle for social policy. The problem is that if the point of social policy is taken to be that of securing the conditions for autonomy, and the nature of autonomy is as described in Chapters Two and Three, then it is unclear - without some external argument - as to where governmental responsibility for health begins and ends. Given the reasonable assumption that resources

would be finite, the external argument would have to establish reasons for denying health care to some who appear, as autonomous persons, to require it, while giving it to others. The external argument would also have to establish where the 'cut-off' point is to be drawn for the allocation of resources to any individual. A hip-replacement for an old person might improve his or her ability to implement autonomous choices, but then so might access to all available means for improving health, including the latest technological innovations (drugs, machines, and so on) as well as clear, unlimited access to medical professionals such as one's General Practitioner. But unlimited access to health care is impractical. In a world of limited resources, one person's unlimited access might well be at the expense of another person's. This suggests that utilising autonomy (at least as we have understood it) as an organising principle for social policy will be unsatisfactory for the same reasons that need and liberty were seen to be unsatisfactory. All of these - need, liberty and autonomy - may provide important objectives for social policy, but none of them seems to be especially foundational since they all must make reference to some further argument in order to set priorities. If the account of autonomy that is to be adopted is the one set out in Chapters One to Three above (and our argument contended that it must be), then serious doubts must be expressed concerning the practical use of this account as an organizing principle for social policy. We remarked in the Introduction to this thesis (pp.12-13) that the project of utilising the reflexive argument in order to establish the priority of autonomy over other objectives was open to criticism from a number of perspectives. But we have now identified a potentially fatal difficulty for this project which is internal to the argument itself.

In Chapters Four and Five, however, we continued the project of exploring the account of personal autonomy developed in the previous three chapters. Chapter four focussed on the concept of 'medicalization' the relevance of which to our argument consists in the claim that engaging with the medical profession in pursuit of health can have a systematically debilitating effect upon one's capacity for autonomy. Three versions of this argument were identified and explored in turn. The first considered medicalization to be a by-product of the medical profession's self-interest. This was seen largely to manifest itself in a concern on the part of the medical profession to defend its scientific status against those medical practices that do not fall within the parameters set by the medical profession itself. It also manifests itself in a concern to opt (more often than not) for scientific, technological solutions to health problems. This was in part a function (as we saw in Chapter Five, **section iv**) of the medical profession's adherence to the individually focussed 'medical model' of disease-causality. Because their attention is focussed narrowly on individual patients, doctors (or so the argument goes) fail to see that ill-health can be a result of environment factors, as much as of pathogens within the patient's body. However, a number of considerations tell against this account of the medicalization thesis. First of all, having established that health is a condition of autonomy, it follows that in successfully restoring a person to health the medical profession will have had a positive effect upon the autonomy of that person. If, as we have argued, ill-health thwarts one's attempt to implement one's autonomously-chosen projects then the restoration of health will remove the impediment to this. This is not to deny that individual members of the profession might, on occasion (and for a variety of reasons), have a

detrimental effect upon the health (and hence autonomy) of individual patients. But the medicalization thesis, in its claim that such an effect is systematic, seems too strong.

The second account of medicalization is also seen to fail for the same reasons. This views medicalization, not as a product of professional self-interest, but as the result of a social process of which the medical profession is but a part. Two accounts of this were considered. The first of these focussed on Ivan Illich's claims concerning the 'professionalization' of modern life; the second focussed on Vicente Navarro's marxist account of medicalization. If we take Illich merely to be stating that life in modern industrial is so complex that we are forced to rely on specialists ('professionals' in Illich's language) for a great many of the services we require, then his theory is relatively uninteresting, since this is obviously true. Illich, however, does not stop there, but goes on to argue that reliance upon specialists undermines our capacity for autonomy. In the field of medicine and health-care, Illich's argument (developed in his Limits to Medicine) is that in taking over responsibility for health, the medical professional systematically robs individuals of their capacity for autonomy. The problem is that Illich's understanding of what it is to be autonomous rests on an assumption of independence, and this (as we demonstrated in Chapter Three, **section iii**) is untenable. It is by no means clear that autonomy would be enhanced if persons had to rely solely on their own resources, and, in a complex society, to attempt to do so could have the effect of seriously compromising autonomy. The resources of autonomous persons are inevitably limited, and there is no reason why they should

not therefore adopt strategies for overcoming such limitations, even to the extent of seeking assistance from people in positions of authority.

Navarro's marxist account of medicalization turns, not surprisingly, on what he takes to be the needs of capital. In one sense, of course, Navarro's argument falls outside the scope of this thesis for we have sought to locate our argument within a liberal framework (see, for example, the distinction made in Chapter Three, **section i**, pp.106-114, between 'liberal' and 'marxist' traditions). Criticism of Navarro therefore involves questioning his marxist assumptions. Although, strictly speaking, this task is outside the scope of this thesis we nevertheless indicated some potential points around which such criticisms might be developed. For example, one aspect of Navarro's argument is that the medical profession reproduces the class structure and ideology of the capitalist society within which it is embedded. But one needs to ask at this point how salient it is (given the way 'capitalist' society has developed and is developing) to talk of present class structures in classic marxist terms. Navarro, for example, pins his hopes for de-medicalizing society on the development of a 'working-class science' and a 'working-class medicine', just as the traditional 'working-class' appears to be vanishing.

The third account of medicalization, which sees the medical profession as an instrument of social control, was explored through the work of Talcott Parsons. Through the concept of the 'sick role', Parsons attempts to argue that the primary function of the medical profession, in sociological terms, is the control of 'deviance', where 'deviance' is understood as behaviour likely to destabilise society. For Parsons,

social action is a function of the roles which govern the behaviour of individuals in a social setting. These roles have normative power so that they generate the values and beliefs that characterise a given society. Society is held in equilibrium just so long as individuals successfully occupy the roles that the social structure (apparently spontaneously) allocates to them. Those who do not occupy roles, or occupy them unsuccessfully, are disruptive to the stability of society. Illness, since it prevents individuals from performing the duties that their roles require of them, is itself potentially disruptive of the social order. The task of the medical profession (which is also its social control function) is to legitimise potentially deviant behaviour by assisting sick individuals into the role of 'patient'. This generates new responsibilities for the potentially deviant (i.e. sick) individual, replacing those temporarily suspended as a result of illness.

From the perspective of autonomy, the central problem of Parsons' account of society lies in its apparently deterministic nature. All that an individual is would seem to be determined by the role (or roles) he or she occupies, and these, it seems, are themselves determined by the social structure. The problem for accounts of autonomy is not so much that the medical profession undermines autonomy, as that the very idea of autonomy cannot be made to fit easily within the Parsonian universe. Individuals might believe themselves to be autonomous and some might value autonomy very highly indeed, but such beliefs and values would themselves be determined by the social structure. We do not extend our criticism of Parsons to encompass the free-will/determinism debate - to do so would be to step beyond the scope of this thesis - but we do conclude that there is little reason to believe that the medical

profession has a systematically debilitating effect upon individual autonomy, even from the Parsonian perspective¹.

In Chapter Five, we considered one particular aspect of health policy in the light of the account of autonomy developed in the first three chapters of the thesis. The point of this was to enable us, through a study of one area of actual social policy, to consider the kinds of implications that might arise for health policy, and for social policy generally, of adopting personal autonomy as an organizing principle for social policy. The area we chose to explore was preventive health care, since this places great emphasis upon the responsibilities that individuals might be said to have for their own health. What was of interest, therefore, was the kind of individuals that this aspect of health policy assumed. In order to facilitate our discussion, we examined the series of documents published under the **Prevention and Health** rubric between 1976 and 1981. Through a discussion of the concept of prevention, we identified a set of problems that preventive policies would encounter, amongst which the difficulty of identifying a 'problem-state' (i.e. the state of affairs to be prevented). The difficulty here resides in the different perspectives from which a state of affairs might be viewed - not only, that is, from the public policy perspective, but also from the perspective of autonomous persons. For example, one thinks of the tendency, still common in an overtly heterosexual social setting, to perceive homosexuality as a 'problem' to be dealt with, perhaps by psycho-analysis. The problem for many homosexuals, however, is not their sexual preference, but the attitude of many heterosexuals to what is, for the former, a fact of their lives. A social policy that

1. On this point see Introduction to this thesis, p.13, n.18

purported to take the autonomy of individuals as its central objective might be expected to guard against the imposition of 'objective' standards upon autonomous individuals, in health, as in other policy areas.

From the point of view of our account of autonomy, the central feature of this campaign that interested us was the use of the 'medical model' of disease-causality to underpin the advice offered in the published **Prevention and Health** documents. The 'medical model' holds that disease has a single causal factor (a virus, for example) which located in the body of an individual. The model assumes that since diseases have a single cause, they require specific individual cures. The individual then becomes the focus of attempts both to cure disease (once it has established itself in the body of that individual) and to prevent it. Thus the **Prevention and Health** campaign focussed closely on the responsibility of the individual in avoiding ill-health. But the medical model of disease-causality was, as we saw, open to a number of objections. First, in apportioning responsibility for health it also has the effect of apportioning blame for ill-health. This might itself have pernicious consequences, where health-care resources might conceivably be withheld from sick individuals on the grounds that they have only themselves to blame. A second objection to the medical model is that it perceives individuals only in isolation from their surroundings. If, as we argued in Chapter Two (**section iii**, pp.84-86) our notion of personal autonomy underpins the attribution of responsibility to individuals (such that if they were not acting autonomously they could neither be held responsible for their actions, nor could they be blamed), and this is coupled with our argument (in Chapter Three) that autonomous persons

must be understood to be partly constituted by (and also partly constitutive of) a social environment, then it follows that health policy founded upon our account of personal autonomy must take this into account. And it follows from this that, since the medical model of disease-causality does not do this, it is inadequate as a basis, at least of preventive health-care policy, but possibly also of health-care policy generally (especially so, given the increasing body of evidence that links health to environmental factors). In other words, given our account of personal autonomy, it would seem that the social model of disease-causality (pp.217-218) ought to provide a more appropriate focus for health policy than the medical model.

* * * * *

What general conclusions might we draw from the thesis as a whole? There seem to us to be two broad conclusions that follow from the arguments contained in the work. The first of these concerns the project of utilising some account of autonomy as an organizing principle for social policy. The second concerns the kinds of policies that might result from adopting the account of personal autonomy developed in this thesis.

The project of utilising autonomy as an organizing principle stems, as we saw, from the allegedly evaluative nature of social policy. Autonomy, and in particular personal autonomy, was supposed to provide a neutral point around which to develop social policy. The account of personal autonomy developed in Chapters One to Three fulfilled this criterion, but was, of necessity, fairly weak, intended to range over all autonomous persons while, as far as possible, avoiding either Kantian

abstraction or 'strong' theories of human nature. However, it was still necessary to locate our account of autonomy - weak as it may be - in relation to a social context. This in turn led us to argue for an 'embodied' account of autonomy that made health an important attribute of autonomy, and (since the point of the account of autonomy was to act as an organizing principle for social policy) justified bringing health within the ambit of social policy. Thus our intentionally weak account of personal autonomy can be said to give rise to a 'strong' conclusion. The problem, as we indicated above (p.235), is that in making health a condition of autonomy, the project of utilising autonomy as an organizing principle seems to be dealt a potentially fatal blow since it is difficult to specify, without some external argument, what level of health is to be the objective of a social policy bounded by finite resources. The fatality might be avoided, of course, by making more explicit than we have done (or have the space to do) the exact nature of the relationship between health and autonomy. In particular, some attention would have to be paid to the socially-constructed aspects of health, and of the way in which individual projects and plans come to be forged. For even though we have tried to demonstrate the contextual nature of autonomy, we have not explored in any detail the relationship between the autonomous 'self' and its context. A full understanding of health in relation to autonomy might possibly make the level of health to be aimed at internal to the account of autonomy. This will have to be explored elsewhere.

In terms of social policy - and given the contextual and 'embodied' account of autonomy developed in Chapters Two and Three - it seems clear that any social policy that organizes around our account of personal

autonomy must pay attention to the way in which individuals relate to their environment. Of course, this itself depends upon a greater understanding of how autonomous individuals relate to their environment (and there are many 'environments' with which they may engage, including social, cultural, political and economic). It also suggests, despite both the intentional weakness of our account of personal autonomy and the fact that our argument has been conducted almost exclusively within the confines of liberal political theory, that the implications for the construction of social policy might potentially be revolutionary.

- End -

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